HEALTH INSURANCE FOR THE UNEMPLOYED

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

AND THE

SUBCOMMITTEE ON PUBLIC ASSISTANCE AND UNEMPLOYMENT COMPENSATION

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

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HEALTH INSURANCE FOR THE UNEMPLOYED

FRIDAY, JUNE 17, 1983

HOUSE OF REPRESENTATIVES, COMMITTEE ON WAYS AND MEANS, SUBCOMMITTEE ON PUBLIC ASSISTANCE AND UNEMPLOYMENT COMPENSATION, SUBCOMMITTEE ON HEALTH,

Washington, D.C.

The subcommittees met, at 9:15 a.m., pursuant to notice, in room 1100, Longworth House Office Building, Hon. Harold Ford (chairman of the subcommittee on Public Assistance and Unemployment Compensation) presiding.

[The press releases announcing the hearing follow:]

[Press release of Friday, June 10, 1983]

THE HONORABLE ANDY JACOBS, JR. (D., IND.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, AND THE HONORABLE HAROLD E. FORD (D., TENN.), CHAIRMAN, SUBCOMMITTEE ON PUBLIC ASSISTANCE AND UNEMPLOYMENT COMPENSATION OF THE COMMITTEE ON WAYS AND MEANS, ANNOUNCE A HEARING ON HEALTH INSURANCE FOR THE UNEMPLOYED TO BE HELD ON JUNE 17, 1983

The Honorable Andy Jacobs, Jr. (D., Ind.), Chairman of the Subcommittee on Health and the Honorable Harold E. Ford (D., Tenn.), Chairman of the Subcommittee on Public Assistance and Unemployment Compensation of the Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a public hearing on health insurance for the unemployed. The hearing will be held on Friday, June 17, 1983, beginning at 9:30 a.m. in the Ways and Means Committee Main Hearing Room, 1100 Longworth House Office Building.

The bill, H.R. 3021, "The Health Care for the Unemployed Act" has been reported by the Committee on Energy and Commerce and has been sequentially referred to the Committee on Ways and Means. The Subcommittee will take testimony on H.R. 3021 and other issues relating to health insurance for the unemployed. Such issues may include eligibility, benefits, distribution of funds to the States, increased administrative responsibility of State unemployment compensation agencies, methods for financing the program and related issues.

DETAILS FOR SUBMISSION OF REQUESTS TO BE HEARD

Individuals and organizations interested in presenting oral testimony before the Subcommittees must submit their requests to be heard by telephone to Harriett Lawler ((202) 225-3627) no later than noon, Wednesday, June 15, 1983, to be followed by a formal written request to John J. Salmon, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. Notification to those scheduled to appear will be made by telephone as soon as possible after the filing deadline.

In order to assure the most productive use of the limited amount of time available to question witnesses, witnesses scheduled to appear before the Subcommittees are required to submit 100 copies of their prepared statement to the Main Committee office, Room 1102 Longworth House Office Building, at least 24 hours in advance of their scheduled appearance.

Each statement to be presented to the Subcommittees or any written statement submitted for the record must contain the following information:

1. The name, full address, and capacity in which the witness will appear (as well as a telephone number where he or his designated representative may be reached);
2. A list of any clients or persons, or any organization for whom the witnesses appears; and
3. A topical outline or summary of comments and recommendations.

For those who wish to file a written statement for the printed record of the hearing, six copies are required and may be submitted by the close of business Tuesday, June 21, 1983, to John J. Salmon, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, Room 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements for the printed record may be furnished for distribution to the press and public if supplied to the Committee office during the hearing.

[Press release of Tuesday, June 14, 1983]

THE HONORABLE ANDY JACOBS, JR. (D., IND.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, AND THE HONORABLE HAROLD E. FORD (D., TENN.), CHAIRMAN, SUBCOMMITTEE ON PUBLIC ASSISTANCE AND UNEMPLOYMENT COMPENSATION OF THE COMMITTEE ON WAYS AND MEANS, ANNOUNCE A CHANGE IN TIME FOR THE HEARING ON HEALTH INSURANCE FOR THE UNEMPLOYED.

The Honorable Andy Jacobs, Jr. (D., Ind.), Chairman of the Subcommittee on Health and the Honorable Harold E. Ford (D., Tenn.), Chairman of the Subcommittee on Public Assistance and Unemployment Compensation of the Committee on Ways and Means, U.S. House of Representatives, today announced a change in time for the hearing previously announced on health insurance for the unemployed. The hearing will begin at 9:00 a.m., Friday, June 17, 1983, in the Ways and Means Committee Main Hearing Room, 1100 Longworth House Office Building.

Chairman FORD. The Ways and Means Subcommittee on Health and the Subcommittee on Public Assistance and Unemployment Compensation will come to order for a public hearing today on health insurance for the unemployed.

The chairman has an opening statement, but I went over to the subcommittee room and we have the director of OMB, Mr. Stockman, with us, and I will just ask that it be made a part of the record.

[The statement of Chairman Ford follows:]

OPENING STATEMENT OF CONGRESSMAN HAROLD FORD, CHAIRMAN

I am pleased to have joined with Congressman Andrew Jacobs, chairman of the Subcommittee on Health, in calling this joint subcommittee hearing on health insurance for the unemployed.

We are all acutely aware that unemployment in this country is at a post-depression high of 10.1 percent. This represents 11.4 million Americans who are out of work. Another 1.8 million workers have lost their jobs but are not in the official unemployment count because they have become discouraged and have stopped looking for work.

The human tragedy behind these statistics lies not only in the inability of jobless individuals to earn a paycheck, but in other far-reaching and debilitating effects.

One of the most oppressive ripple effects of unemployment is the loss of job-related health insurance. Fourteen million unemployed workers and family members are currently without health care coverage, including four million children.

Loss of health insurance for the unemployed comes at a time when they need it most. The stress factor alone makes jobless individuals and their families more vulnerable and susceptible to health problems.

Recent statistics show that for every 1 percent rise in unemployment, there is a 2-percent increase in the mortality rate, about a 2-percent increase in cardiovascular deaths, a 5 percent to 6 percent increase in homicides, a 3-percent increase in first admissions to mental hospitals, and about a 5-percent increase in infant mortality.

These statistics reveal a staggering and alarming correlation between unemployment and the health of the individual. These statistics also make it clear that the unemployed population needs health insurance even more than those of us who are working.

Public hospitals, which are traditionally the lifeline to health care for the poor and medically needy, are being forced to turn away many patients who are uninsured and who cannot otherwise afford to pay. This added condition makes hopeless an already desperate situation for uninsured individuals.

The unemployed who lose employer-based health insurance protection are generally unable to obtain coverage under other existing public health care programs. In some instances, unemployed families can gain health insurance through medicaid. But in 27 States, medicaid does not cover either impoverished unemployed two-parent families or their children.

As chairman of the Subcommittee on Public Assistance and Unemployment Compensation, my utmost concern is to find a measure that provides necessary health care assistance for the unemployed, and one that can be quickly enacted.

The unemployed who have lost their health care benefits are in a situation which they did not create, and over which they have no control. Federal help is crucial in easing their access to health care while they are waiting for jobs to become available.

The Subcommittee on Public Assistance and Unemployment Compensation is pleased to hear testimony today on a bill which I cosponsored, H.R. 3021, the Health Care for the Unemployed Act. Testimony will also be received on alternative proposals that address the problem of health care for the unemployed.

I welcome the witnesses appearing before these subcommittees today. I look forward to hearing your testimony.

Chairman **Ford**. We will proceed now with the Honorable David A. Stockman, Director of the Office of Management and Budget.

Mr. **Gradison**. Thank you, Mr. Chairman.

I would like to join you in welcoming Director Stockman. We all on the committee appreciate the efforts you made so you could be here this morning on this very important subject.

Chairman **Ford**. Mr. Shannon.

Mr. **Shannon**. Welcome, Mr. Stockman. We promise not to bring up the tax cap if you promise not to bring up the tax cap.

Chairman **Ford**. I would also like to say that Mr. Jacobs, chairman of the Health Subcommittee, had a conflict in his schedule and cannot be with us this morning.

STATEMENT OF HON. DAVID A. STOCKMAN, DIRECTOR, OFFICE OF MANAGEMENT AND BUDGET

Mr. **Stockman**. Thank you very much, Mr. Chairman and members of the committee.

With your permission, I would like to follow your precedent and include my lengthy statement in the record and maybe spend 8 or 10 minutes summarizing.

I believe the key points the administration would like to convey to the committee as you attempt to mark up this bill---

Chairman **Ford**. Your statement will be made a part of the record.

[The prepared statement follows:]

Statement of the Honorable David A. Stockman, Director, Office of Management and Budget

Mr. Chairman, thank you for the opportunity to appear before your Committee today to discuss the problem of health insurance for the unemployed. I come before you today to share with you the Administration's views on the nature and dimensions of the problem, and to outline the Administration's views of appropriate—and inappropriate—remedies to address it.

SUMMARY OF RECOMMENDATIONS

Our primary conclusion, Mr. Chairman, is that the problem of lack of health insurance among the unemployed is one of selective gaps and discontinuities—and not a pervasive or general problem. As I will discuss in more detail shortly, the number of long-term unemployed who are wholly without access to health care services is really a limited subset of the unemployed. The Administration believes that the needs of this group can be met by a package cf policy reforms such as the following:

Requirements for employer insurance packages that ensure the unemployed access to continued coverage when they become unemployed.

Requirements for employer insurance packages to ensure that the unemployed can be enrolled under a working spouse's health plan should they become unemployed and lose their own employer coverage,

Amendments to the Social Services Block Grant Act to provide that funds available to the States can be used to fill in whatever gaps in coverage remain; and

"Pay as you go" financing for any additional funding under title XX through enactment of the Administration's proposed limits on tax exclusion of employer insurance contributions at a level below that originally proposed.

DEFINING THE PROBLEM CAREFULLY

Our support for these measures—and our belief that these steps will be more than adequate to address health coverage problems among the unemployed—is based on our study of the access of unemployed Americans to health care services. The general perception, Mr. Chairman, is that all unemployed American families somehow confront common problems due to the misfortune of unemployment. We have concluded, however, for the reasons discussed below, that lack of access to adequate health care is not a generic problem associated with unemployment, per se, and that in fact the great majority of the unemployed are not being denied care.

Continuation and conversion privileges

The truth is that many employers presently provide extended coverage to workers who are on layoff. In many cases, such coverage extensions are benefit plan features obtained as a result of collective bargaining. In other instances, employers offer coverages of this sort unilaterally. In any event, most insurance plans, enrolling workers as they do on a month-to-month basis, cover laid-off workers at least until the end of the month in which they are terminated. Such automatic extensions can provide up to four weeks of additional coverage even if there is no employer-financed extension. Many families use this remaining eligibility to actually obtain medical services family members may need.

Additionally, as of March, a number of States provide, as a matter of law, that workers may continue to enroll in a health insurance plan. In 19 States, employers are required to offer continued coverage to former employees at group insurance rates. In 30 States, employees must be offered the option of converting to individual health insurance plans. While these practices required laid-off workers to finance coverage out of their own resources, families with significant medical expenses at the time of termination are provided the means to limit their exposure without regard to pre-existing medical conditions. In most such instances, these features provide considerable protection.

Range of unemployment duration

Even in instances where employers do not continue health insurance for laid-off workers, several pieces of available data suggest that the problem is not as large as is commonly perceived.

The best available evidence is that even during the economic recessions the labor force is a dynamic one and duration of spells of unemployment for most unemployed individuals remains relatively brief.

TABLE I.—PERCENTAGE DISTRIBUTION OF UNEMPLOYMENT SPELLS

	Percent			Average weeks
	Short (1 to 4 weeks)	Medium (5 to 26 weeks)	Long (27 + weeks)	
1982	41	48	11	14.3
1978	49	46	5	8.3

In 1982, the worst year for unemployment since World War II, the average spell of unemployment lasted just over three months. Although the average unemployment spell was much longer than it was during a non-recession year such as 1978, it was still the case in 1982 that two out of every five spells of unemployment lasted for less than one month.

Although many individuals experienced more than one spell of unemployment during 1982, the data still reveal that for most Americans unemployment is a temporary phenomenon. Long-term unemployment, which results in a severe strain on family resources, tends to be concentrated on a small but significant portion of Americans. But even during the most difficult economic times, such as last year, only 11 percent of all spells of unemployment lasted longer than six months.

Family resources

Despite the vast array of social welfare programs, the family remains the primary social institution that cushions individuals from the financial hardship of unemployment. We often tend to view the unemployed, especially those with long durations of unemployment, as a homogeneous group in need of financial assistance. In fact, the family provides the main source of financial assistance for the unemployed. Although data for 1982 are not available yet, data for 1981 provide some indication of the financial resources of the unemployed in a recession year.

TABLE II.—FAMILY INCOME OF THE UNEMPLOYED IN 1981

	Total	Duration of unemployment	
		Short-term (1 to 4 weeks)	Long-term (26 plus weeks)
Average family income	$20,898	$23,113	$17,035
Percent with family income greater than $20,000	44	51	33
Percent with family income below poverty line	19	14	31

As the data in the accompanying table indicate, the financial circumstances of the unemployed vary enormously. In 1981, for example, 44 percent of all unemployed individuals lived in families with incomes in excess of $20,000.

On the other hand, 31 percent of all individuals experiencing six months or more of unemployment lived in poverty, while over one-third of the long-term unemployed lived in families with incomes in excess of $20,000.

Of course, even families with substantial resources can experience cash flow difficulties that compel them to use their savings to tide them over spells where one family member is unemployed. But we should not conclude that such families will be unable to afford either health insurance coverage or actual medical expenses simply by reason or length of unemployment.

Coverage through working spouses

The primary reason that family incomes remain relatively high among many of the unemployed is the presence of secondary earners in the household. In 1981, over 80 percent of the average family income among the unemployed represented earnings of family members. Although the 1981 data may not be representative of current conditions, the most recent statistics for the first quarter of 1983 indicate that the proportion of unemployed family members who have other family members working remains high. Among all unemployed individuals in families, 65 percent have other family members at work.

Besides providing an additional source of income, working family members are also a potential source of health insurance coverage for the unemployed. While accurate data on family coverage among secondary workers is unavailable, many hold insurance coverage through their employer.

Some idea of the size of the non-covered unemployed population can be obtained by a close inspection of family characteristics among unemployed individuals:

TABLE III.—*Characteristics of the unemployed, 1983*

	Millions of individuals
Family type: Total unemployed in families	10.5
Intact families:	
Married persons with working spouse	3.3

	Millions of individuals
Dependents with working family member	2.4
Subtotal	5.7
Single-parent potential medicaid families:	
Female-headed	2.1
Male-headed	.6
Subtotal	2.7
Unemployed sole wage earners	2.1

As is indicated in the accompanying table, 10.5 million individuals living in families experienced some unemployment during the first quarter of 1983. Among the 5.2 million unemployed married persons, 3.3 million had working spouses. Unemployed husbands with working wives represented just over half of this group. Also, unemployed relatives in intact families with a working husband or wife numbered 2.4 million over the period. Therefore, of the 10.5 million unemployed individuals, 5.7 million lived in intact households with at least one parent employed, and hence were potentially eligible for coverage.

In addition, 2.7 million of the unemployed lived in single-parent potential Medicaid-eligible families. Subtracting both of these groups from the total yields a population of 2.1 million Americans who are unlikely to have a source of employer- or Medicaid-provided health insurance. This number represents a reasonable—but lower-bound—estimate of the totally uncovered population of unemployed family members.

One reason why this population represents the lower bound is obviously that, in certain instances, spouses may have elected to either accept self-only coverage, or may have elected family coverage through the spouse who became unemployed. As I will indicate later, however, this problem can be addressed without great difficulty.

Other public programs

We should also note that the total estimate of the unemployed includes many families that are eligible for public assistance, and who therefore qualify for and receive Medicaid coverage. In 22 states, two-parent families can be covered under Medicaid. In 30 states, families can be covered, even if they are not eligible for cash assistance, thorough "medically needy" programs. In such cases, high medical expenses are deducted from income to expand Medicaid eligibility to those who are poor by reason of high medical expenses. While the Medicaid program does require an asset test, the value of the family's home and automobile is not counted for this purpose. Thus, those long-term unemployed families most is need of assistance can receive it, in most instances, through existing public sector mechanisms.

Medicaid, of course, is not the sole effort directed at the health care needs of low-income families by the public sector. In the Administration's Fiscal Year 1984 budget, Mr. Chairman, over $85 billion is provided for health care services—ranging from community health centers to immunization programs.

Private sector efforts

Our present health care system is characterized by voluntary private efforts to provide health care services to those who need it. There is strong evidence that those in the private sector have in fact expanded their efforts during the last few years to meet the needs of those who have become unemployed during the recession.

Private physicians have a long and commendable history of meeting the needs of those with limited resources. As the American Medical Association testified in April before the House Health Subcommittee, 70 percent of all American physicians provide reduced rates or free care services to those unable to afford care. A surprising 10 percent of all physicians are actually donating their time to special programs for unemployed workers and their families.

Hospitals have been and remain active. As the National Association of Countries has testified, 98 percent of the Nation's largest hospitals provided over $750 million in uncompensated care in 1980. The evidence available to us suggests that this commitment to providing care regardless of compensation has, if anything, expanded markedly in the past few years. This sort of commitment, Mr. Chairman, goes far beyond explicit legal commitments, such as the charity care obligations under the Hill-Burton program, to provide fee care. Rather, the Nation's community hospitals, which after all are established as private non-profit charitable instititutions, have maintained a long tradition of providing care without regard to the ability to pay.

Insurers and other third-party payors have also been active in meeting the needs of the unemployed. In six States, special insurance pools have been established to provide inexpensive coverage to the unemployed. And in April, Blue Cross/Blue Shield of Western Pennsylvania announced a special program at heavily-discounted rates to unemployed workers and their families.

Coverage for physician services, for example, will cost only $8.50 per month for full family coverage. Coverage for hospital services will be provided at a 75 percent discount, both through low rates and by waiver of normal deductibles.

In all, the Administration believes that we must recognize the existence of these commendable efforts as we work to fashion solutions in this area.

AVOIDING LEGISLATIVE OVERKILL

As the foregoing has suggested, the problem of accessible and affordable health care services for unemployed workers and their families really consists of a number of special cases of individuals. Failure to recognize this fact in the development of legislation could prove a costly mistake. As you are aware, Mr. Chairman, the natural tendency of the bill-writing process is to expand consideration to an ever-wider scope of circumstances as special conditions and situational anomalies are brought to light. The danger is that the remedies fashioned to address these anomalies often result in adding in whole new classes of beneficiaries for a program despite the fact that only certain individuals within the stated class may have true needs that cannot be addressed some other way. As I will illustrate, Mr. Chairman, that danger is particularly present in the area of providing health insurance coverage to those who are presently uncovered.

The dilemma of equally worthy claims

The cause being considered by your Committee is the plight of those unemployed workers who previously had employer-financed health insurance, but lost it as a result of involuntary unemployment. Yet the problem of lack of health insurance coverage is not restricted to this group. There will be a strong temptation for legislative expansion as the circumstances of the target population are compared to the plight of:

Unemployed families without prior coverage;

Employed workers with no employer coverage;

Low-income families with no recent work history who are ineligible for Medicaid; and

Self-employed workers who receive no special tax breaks for health insurance.

As we learned long ago in the national health insurance debate, our society simply cannot afford to go all the way down this road. Yet if we move forward with an explicit Federal entitlement program in this area, we will be hard-pressed to explain why coverage should be bestowed on a narrow subset of the some 30 million Americans who are without health insurance.

The minimum benefits problem

A complementary problem with attempting to addresss the needs of the unemployed through an explicit benefit program is the problem of establishing some minimum acceptable coverage package. On the one hand, the need to restrict costs would argue for some narrowly defined set of benefits—perhaps restricted to so-called "catastrophic coverage", in which full coverage is provided only after the beneficiary meets some high deductible. Yet the very nature of such coverage would call into question whether any real benefit is in fact being conferred. To the extent that the unemployed have financial problems, the second $500 of unaffordable expenses is just as insurmountable as the third. Attempting to draw the line in a way that is generally recognized as fair is probably impossible.

It is easy, however, to understand the fiscal stakes involved. Suppose the target population were restricted to 2 million families—the rough number of families who have lost prior coverage that we estimate will still be on unemployment insurance on October 1. Extremely limited catastrophic coverage might cost perhaps $20 per month per family, or only $480 million annually. Yet present employer coverage plans with full benefits—even at group rates—can cost over $180 per month per family. Moving from the low end to the high end of coverage—a normal tendency in these matters—could raise costs nearly tenfold to nearly $4 billion annually.

The prohibitive cost of a new entitlement

If we examine the potential for exapansion due to these two factors, we are forced to conclude that any explicit Federal entitlement effort in this area would quickly escalate beyond affordable levels. Providing all eleven million unemployed workers with full family coverage at $180/mounth would cost an astonishing $19 billion annually. Even recognizing that many of the unemployed are single individuals and assuming a blended average cost of full coverage of $135 per month, the upside threat is in the $14 billion dollar range. The following table summarizes the potential cost range:

TABLE IV.—COST OF COVERING VARIOUS GROUPS WITH HIGH AND LOW OPTION BENEFITS

[Dollars in billions]

	UI beneficiaries		All unemployed
	With prior coverage	All	
Type of benefit:			
Number in eligible families (millions)	(4.0)	(5.5)	(17.4)
Catastrophic with $1,500 deductible ($22.50/month)	$.5	$.6	$2.1
Catastrophic with $500 deductible ($49.50/month)	1.1	1.3	4.6
High option plan ($180/month)	4.3	5.8	18.6

The actual fiscal threat is unknowable

I would caution, moreover, that the Federal government's track record in estimating the cost of new health care entitlements offers little solace as we go forward in this area. For instance:

Medicare.—Shortly after the enactment of Medicare, the Social Security Trustees Report (1966) estimated that outlays from the HI and SMI trust funds would rise, in real terms, by 5.2 percent and 2.3 percent annually, respectively. In fact, the programs grew by 9.3 percent and 10.2 percent annually in real terms. As a result, a fiscal year 1988 projection for SMI outlays would have been $5.6 billion under the original estimates; in fact, we now expect that SMI will hit $36.5 billion in fiscal year 1988, a 548 percent overrun from the perspective of the original forecast. Similarly, the original estimate would assume, by 1990, HI outlays totalling $26.6 billion. The current forecast, however, is for HI outlays to hit $116.1 billion in 1990—a 366 percent overrun.

ESRD.—The 1973 Social Security Trustees report estimated ESRD costs for Fiscal Year 1977 at $252 million. Actual fiscal year 1977 spending was $310 million, almost 25 percent higher than estimated costs. Not surprisingly, fiscal year 1983 spending for the ESRD program is estimated at approximately $2 billion, about 20 times the initial program costs level in fiscal year 1974.

Home Health Care.—Three years ago, home health care benefits were liberalized through the elimination of coinsurance and the 100 visit per year limit. Two years later, the result was a doubling of home health program costs.

Unknowable behavioral effects

The reasons for these overruns are the prodigious incentive effects built into the health care field.

On the beneficiary side, health care is considered such a superior good that consumption is limited only by income. Once a new entitlement is created obviating income limits, utilization of services climbs toward the sky.

On the provider side, the capacity for product upgrading and service improvement is constrained only by aggregate demand for health care services. Once an entitlement is created to fund whatever service consumption level is demanded, the "intensity" of service provided—more doctors, nurses, supplies and machines—is limited only by technological advance and labor supply constraints.

FIRST THINGS FIRST

I would hope, Mr. Chairman, that we have learned our lesson in this field—that medical care entitlements strain the limits of the largest economy in the world. In fact, recent developments make clear to me that we are hard-pressed to afford the medical entitlements we now have on the books—let alone being able to afford new ones. As recent studies from all directions have amply demonstrated, the HI trust fund is headed for bankruptcy at some point between 1987 and 1990. In order to stave off bankruptcy of this existing entitlement system, we will somehow have to contend with a projected $600 billion mismatch between income and outgo to the trust fund between now and the end of the century. This Committee knows well the magnitude of the task before us in either restraining benefits or raising revenues to fund this astronomical shortfall. Adding in new problems will only compound the difficulty of the task.

The sobering fiscal situation

Even in the best of fiscal circumstances—such in as the halycon days of the late 1960's when the Federal government committed the projected "fiscal dividend" to many worthwhile purposes—major new entitlement commitments should only be carefully undertaken. In the present environment, with projected deficits stuck permanently in the 5-6 percent of GNP range in the absence of concerted policy action, the creation of major new entitlement programs would be the height of fiscal irresponsibility. The following table summarizes our current plight in the entitlements area:

TABLE V.—PRESENT ENTITLEMENTS COMMITMENTS

Category	CBO estimates in billions of dollars			
	1984	1985	1986	Total
Total entitlements	392	416	444	1,252
Social security savings	−3	−3	−4	−10
Further Senate savings		−1	−3	−4
Further House changes	7	5	2	14
CBO baseline deficit	197	200	213	610

As the table shows, the Congress has, to date, been able to enact only $10 billion in entitlement savings of a $1.3 trillion spending base—savings of only 0.8 percent. This includes $2.1 billion of 1986 savings achieved through adopting the Medicare prospective payment provisions as part of the Social Security bill. Apart from these savings, the Senate resolution can find additional net savings totaling only $4.1 billion, while the House calls for increases of $13.4 billion. Under current law, total entitlement spending will rise by 13 percent over the next three years. In this environment, further expansions of the entitlements base would be unconscionable.

H.R. 3021: AN INAPPROPRIATE REMEDY

Having described the scope of the problem and inappropriate remedies in general, let me translate these observations into specific concerns regarding H.R. 3021. First, H.R. 3021 would entitle the unemployed the health benefits independent of either their access to private health insurance or other financial resources. Almost all the unemployed—over 19 million individuals and family members—would be eligible for benefits. This approach ignores the fundamental nature of the problem which I described earlier. The lack of health insurance is not pervasive; the problem is one of gaps and discontinuities in coverage among them.

Second, in an attempt to extend coverage to the entire unemployed population without carrying a $10 to $20 billion price tag, H.R. 3021 provides a limited and unique benefit package. Benefits are capped at nine days of inpatient care and ten days of outpatient care. This affords the unemployed virtually no protection against the high cost of catastrophic and long-term illness and injury. The bill, by providing minimal health care coverage too many individuals who do not need it, ends up providing too little of the wrong benefits to those with acute high cost illnesses—aspirin in these cases is insufficient.

Third, providing an extremely thin benefit package to a broad-based heterogeneous population sub-group is certain to create an explosive entitlement growth dynamic which this Nation cannot afford. The benefit package would quickly be recognized as too limited and would be expanded. The lack of eligibility among those with equally pressing health needs—low-income employed workers with no employer coverage, self-employed workers with no special health insurance tax breaks—would soon be recognized and eligibility would be expanded. The inevitable result would be a new runaway entitlement whose costs would far outstrip the bill's already excessive $6 billion price tag.

Fourth, H.R. 3021's wholesale adoption of Medicaid's complex regulations is inconsistent with its being a temporary program. The bill incorporates 25 separate state requirements from Medicaid, including detailed periodic reports and provider standards. It also adds detailed requirements for beneficiary notification and eligibility verification. These rigid and burdensome networks of regulations will delay state implementation resulting in an unnecessary waste of scarce resources.

Finally, the state allocation formula produces unnecessary budgetary planning confusion and uncertainty. Under the formula, state allocations are revised on a quarterly basis. As a result states will be subject to sudden and, in many cases, significant variations in available federal funds. The addition of a state match, dependent upon a wholly separate series of factors, will only exacerbate state planning problems as they attempt to deal with unforeseen shifts in state funding requirements. H.R. 3021's variable matching rates will not necessarily target assistance to states with the highest unemployment. For example, only three states, comprising 6.9 percent of the Nation's unemployed—Alabama, Michigan and West Virginia—would qualify for 100 percent matching. States with unemployment rates under 6 percent receive no funds at all.

For these reasons the Administration opposes H.R. 3021. It establishes precisely the type of program that we want to avoid—one that is simultaneously ill-suited to address the problem and contains all the ingredients for an explosive new entitlement. The Nation neither needs or can afford this.

THE ADMINISTRATION'S VIEWS ON AN APPROPRIATE REMEDY

To meet the needs of those for whom unemployment is a barrier to care, the Administration would instead direct the attention of your Committee to a number of areas in which we believe constructive action can be taken.

Based on our analysis of the scope of the problem, the Administration concludes that there are three classes of unemployed individuals who are presently unable to obtain health insurance or needed health care services:

Families where one spouse has lost coverage in which the family is unable to reenroll in the health plan of the other working spouse due to restrictive employer open enrollment practices;

Families which would be able to afford to continue their present coverage or perhaps purchase a less costly plan, but are discouraged from doing so due to the difficulty of finding private market alternatives, or due to considerations of age or illness that make them poor risks; and

A residual group of long-term unemployed who do not fall in either of the above classes who are ineligible for Medicaid, and unable to avail themselves of other public or private aid.

The Administration believes that the needs of these families can be met by a five-part plan based on the following three principles:

1. *Support and encourage private sector initiatives:* First, the Administration believes that much of the present hardship can be alleviated by constructive actions of the States and the private sector to meet the health care needs of the unemployed. Over the next few months, we plan to call attention to these efforts, and to encourage States and private institutions and individuals to emulate the many commendable efforts already underway. I would urge the Committee to undertake a similar effort, to determine ways in which we at the Federal level can be of assistance in promoting such efforts.

2. *Augment Existing Private Insurance Coverage—Provide Incentives for Increased Access:* The Administration will also support efforts through legislation to ensure greater access among the unemployed to private insurance coverage.

3. *Federal Support Tied Directly to New Financing:* Third, the Administration will also support budget-neutral efforts to assist those for whom increased access and private sector and State assistance is deemed insufficient. If the Committee determines that increased resources are needed for this purpose, the Administration will support increased funding if and only if the Committee also provides a commensurate level of revenues, beyond those provided for in the President's budget proposals, to prevent increases in the deficit.

Legislative changes

The specific legislative measures which the Administration would support are:

Mandated Coverage/Conversion Privileges: The Administration would support amendments to the Internal Revenue Code to mandate:

Continuation of the present employer plan beyond termination at individual rates, at the expense of the former employee, for the lessor of one year or the period of unemployment; and

An option for former employees to convert to a special low-cost "catastrophic" insurance plan at market rates, at the expense of the former employee, for the same period of eligibility.

The combined effect of these provisions would be to ensure unemployed workers access to a health insurance plan without disqualification for pre-existing conditions or other circumstances. By eliminating the need for the unemployed to seek out and find their own coverages, more families are likely to avail themselves of coverage.

Mandatory Open Enrollment Upon Termination of a Working Spouse: The Administration would also support legislation to ensure that individuals who lose insurance coverage at unemployment can be enrolled speedily in a plan available to their spouses. Specifically, the Administration would support:

Permitting workers who had previously elected self-only coverage to elect full family coverage when a covered working spouse becomes unemployed; and

Permitting workers who had previously elected not to accept coverage in favor of enrollment in a working spouse's plan to elect full family coverage should that spouse become unemployed.

As noted earlier, 40 percent of the unemployed have working spouses. While precise estimates are unavailable, we believe that the combined effect of these provisions will ensure coverage for a significant share—perhaps as many as one-third—of the unemployed.

State Assistance Through the Social Services Block Grant: The Administration would also support amendments to Title XX of the Social Security Act to make State provisions for health insurance for the unemployed an eligible activity under the Social Services Block Grant. In doing so, the Administration believes that the broadest possible latitude should be granted to the States to establish eligibility, benefit and delivery mechanism provisions. In that way, States will be able to use the funds available to them to assist those who are uniquely in need of help within their own States.

If the Committee agrees with this recommendation, and wishes to provide added financial resources under that title to the States for this purpose, the Administration could support such increased funding only if additional revenue measures are enacted to finance whatever incremental increase the Committee finds appropriate. Specifically, the Administration would support simultaneous enactment of the Administration's proposed cap on the exclusion of employer contributions from Adjusted Gross Income as an acceptable method of financing. Any funding increase under title XX, however, would have to be matched with a corresponding decrease in the level of the monthly exclusion cap below the level—$175/month for family coverage—that the Administration has proposed.

For example, enacting the cap in 1984 at the $160/month level would increase revenues in calendar year 1984 by approximately $500 million above the level assumed in the President's budget.

Besides providing the resources necessary to finance a health benefit program, the tax cap has several additional advantages. The cap would reduce the inflationary pressures built-in to our health care system. The current tax treatment of employer-provided health insurance creates incentives to purchase elaborate and expensive health insurance policies with low cost-sharing and first dollar coverage. These policies foster the use of "free" health services and provide no incentives to avoid excessive utilization. The result, as we have witnessed, is spiralling health care costs. The tax cap is not the cure-all for the inflation, but it is a significant step in the right direction.

The tax cap would also reduce an inequity inherent in the current tax treatment of employer provided health insurance. Under the present treatment, a given health benefit package is "less expensive" for high income workers then it is for low income workers. Or to cast the inequity in a different light, a high income worker can purchase a more generous benefit package than a low income worker at the same "price." The tax cap is a simple and expedient method of addressing this anomaly.

Several objections to the tax cap have been raised. Although many of these objections appear at first blush to have merit, upon closer scrutiny they cause little reason for concern.

One objection is that reveune estimates from the tax cap are overstated: employers will cut back on health benefits in favor of other tax free benefits. Let me begin by saying that revenues are not the primary issue. The tax cap is designed to control skyrocketing health care costs. With respect to the estimates, both the Administration and Congressional revenue estimates have factored in this behavioral effect. Moreover, to the extent that the tax cap lowers health care costs, it will result in an additional budget savings.

A second objection is that the cap would have an uneven regional impact due to variations in health care costs. A review of Census Data shows only a weak relationship between the level of employer contributions and health care costs. Costs have been high in partly because of the treatment of employer contributions. In general, wages are higher in high-cost areas, reducing the differential impact of the tax cap.

A third objection is that the tax cap would unfairly penalize certain workers. Some charge that employers would be reluctant to hire older workers because of their higher health care costs. Older workers have smaller families, so the cost of insuring them must be adjusted for this factor and employers hire and retain them for the value of their experience. Workers in high-risk occupations would not be penalized. Their jobs generally pay higher wages with which workers can buy more comprehensive coverage.

A fourth objection is that the tax cap may reduce preventive services by encouraging minimum benefit packages. On the other hand, the tax cap would induce employers to purchase health plans which would encourage employees to seek preventive services in order to avoid more costly services.

A final objection is that the tax cap is expensive and complex to administer. The tax cap would generate multiple choices in health plans resulting in increased competition among insurers, thus reducing insurance plan costs to employers. The reduction in these costs should more than offset the increase in administrative costs. Employees would also benefit from a greater choice of health plans. Plans which currently offer multiple choices to employees should already have the core administrative structure necessary to comply with tax cap. Employers whose administrative costs are high as a result of employees exceeding the cap would purchase insurance plans with costs below the cap. Employees who desire more expensive health plans would contribute to these plans with after-tax out-of-pocket dollars.

In closing, the Administration would welcome the opportunity to work together with the Committee to produce legislation within the scope I have just outlined. We are hopeful, Mr. Chairman, that any legislation developed by this Congress to address the health care needs of the unemployed could be fashioned in a manner that the President could accept. I look forward to working with you and your Committee toward achieving that end, and would welcome any questions that the Committee might have.

Mr. STOCKMAN. Thank you, Mr. Chairman.

When it became clear Congress wanted to act to this issue in about March, the administration undertook a major study and scrutiny of the entire issue to see what we ought to recommend in the area of a Federal program and initiative for health benefits for the unemployed.

The major conclusion we came to was that lack of access to health insurance or affordable health care is not a systemic or generic condition among the unemployed. But at the same time, serious hardships exist for selected groups and warrants a Federal response.

Moreover, we concluded that lack of ready availability of coverage to many of the unemployed is a greater problem than affordability, and we are proposing steps to remedy that issue as well.

We would recommend the committee avoid a sweeping generic solution—that is, uniform medical entitlement to the unemployed as provided in the Energy and Commerce bill referred to your subcommittees—and that instead you pursue a more measured approach, a multipronged strategy that carefully addresses the heterogeneous problems that actually exist.

We would propose that the first element of such a multipronged strategy be broadened family health protection through mandatory open enrollment for working spouses. By our reckoning, 3.3 million or nearly 30 percent of those who experienced unemployment in the recession peak, first quarter of 1983, the January to March period, had working spouses, and another 2.4 million of those who were unemployed were dependents living in intact families with one or more other working members.

Thus, overall, 5.7 million, or nearly 50 percent of the unemployed in the peak first quarter, peak recession quarter of 1983, were in multiple-worker families with a high probability of employer coverage available, at least to one member, and certain income available to purchase private temporary benefits, if they were available.

So by mandating open enrollment so that the entire family can be protected by the policy of the remaining working member, we believe that a significant proportion of the financial and health threat to the temporarily unemployed can be alleviated, and we would urge the committee to include the open enrollment provisions in the legislation that you report.

The second element of the multipronged strategy that we have recommended concerns broadened access to continuation coverages for those who are temporarily laid off. Here I would suggest to the committee that we confront an anomalous juxtaposition of facts.

On the one hand, a signficant proportion of the unemployed have both short spells of unemployment and relatively high incomes. In 1981, for example, 44 percent of the unemployed had family incomes in excess of $20,000 annually, and the average family income was $20,500 for unemployed married men and in excess of $24,000 for unemployed married women.

Second, in the recession year of 1982, the average spell of unemployment lasted only 14.3 weeks and 41 percent of unemployment spells lasted less than 4 weeks, or 1 month.

Now, from both vantage points, the problem among this segment of the unemployed, those with relatively high annual incomes or with short spells of unemployment, is not lack of income or affordability in terms of health care, but availability of temporary health care coverage.

On the other hand, the underlying dynamic and structure of our health insurance system, which is preponderantly workplace based and group plan rated, works a needless injustice in terms of this segment of the unemployed, those with relatively high incomes or short spells that I have just described.

Families with income to buy temporary coverage find it difficult to obtain in many cases due to the high cost of individual policy retailing, disqualification for preexisting medical conditions, or adverse risk premiums apparently built in to individually retailed or sold policies.

Therefore, we suggest that this mismatch of relative ability to pay and relative unavailability of reasonably priced coverage be alleviated with two continuity of benefit mandates.

The first would be a right to purchase existing employer plans for up to 12 months after termination, or until reemployment. The second mandate would be the right to purchase from the former employer's carrier, insurance carrier, low cost catastrophic plans at the option of the employee.

Let me stress to the committee that this would not involve either a Federal or an employer subsidy, but it would permit the temporarily unemployed who do have incomes to buy into the mainstream system of relatively cheaper employer-based health insurance coverage.

Then the third component is this: We recognize that not all of the unemployed are members of households with other workers or other coverages, and that a segment of the unemployed consists of those who face serious hardships due to long or multiple spells of unemployment or exhaustion of UI coverage or exhaustion of family resources and assets. In these cases, in this third segment of the unemployed, we recommend two steps.

The first would be to open title XX of the social services block grant for medical coverage in hardship cases, with broad State discretion as to eligibility, benefit packages, copayments and so forth.

Second, we adhere strictly to pay-as-you-go financing in the form we have recommended of a tighter tax cap on the exclusion for health benefits. We estimate that a tax cap of $1.60 per month would generate $500 million in excess of what we have proposed in the budget and could be used to fund the additional expenditures under the block grant that we are recommending.

Now, let me stress two important aspects of our recommendation for the members of the committee here this morning. First, the administration strongly opposes—indeed, cannot accept—any new broad entitlement program, especially a nonmeans tested program available to the broad middle class.

I would remind the committee that already built into current law for the next 5 years, fiscal year 1984 to 1988, is an entitlement cost that approaches $2.2 trillion for the existing range of medical, pension, means tested and other entitlements that we have on the books today.

But beyond the social security bill and the medicare component that is already enacted into law, the Senate Budget Committee could recommend only $24 billion in savings over the next 5 years out of that $2.2 trillion base of existing commitments. And that is only 1-percent savings; 99 percent, in their view, is locked in.

In the House budget resolution, no savings were targeted; indeed, this $2.2 trillion base of existing entitlements would have been increased by some $6 billion.

Now, whatever the merits are of this whole range of programs in the existing entitlement base, I think it should be obvious to everyone, and I am sure it is obvious to members of this committee, that financing these existing commitments that have been made over the years will be nearly an unsupportable problem. We simply cannot afford to launch another open-ended entitlement in this context.

Moreover, given the skyrocketing costs of medicare and medicaid alone, even the largest economy in the world can't afford a third medical entitlement exposure. As members of this committee well know, in the case of medicare alone, we are now looking at the prospect of a $600 billion shortfall in the years 1987 to 2000 just to fund the existing medicare system.

So I would suggest this morning that for all practical purposes, the Federal Government is insolvent already, with built-in expenditures for all purposes exceeding current law revenues by $1 trillion over the next 5 years. Therefore, any new money for any new program, no matter how meritorious, as in the case before the committee today, must be tax financed in the same bill that creates the expenditure.

For anything new that we do, pay-as-you-go financing is critical, essential, and a necessary condition for legislative action.

Mr. Chairman, let me conclude with a few comments on the draft proposal for an alternative approach to health benefits for the unemployed that has been circulated by this committee and by Mr. Rangel in the last couple of days.

I would first note that in our view this is a decided improvement over the Energy and Commerce bill that was referred to the committee. It creates a block grant via title XX, as the administration has recommended, and we endorse that feature.

It contains a definite sunset, indicating that the committee intends this to be a temporary program, and that obviously is similiar to our recommendation. However, we would suggest a date of October 1, 1985, to your 2-year program, and this would give ample time for the program to be revisited in the 1985 session of Congress to determine whether the program ought to be continued at that time. There is not need for a 3-year temporary authorization in this situation.

Third, we note that it provides a great deal of flexibility in the design of programs to the States, including a permissible income and asset test, a permissible waiting period choice, a permissible maximum eligibility period. All of these flexibility features, we believe, are essential if we are to have a temporary program that becomes effective and operational quickly and that can deal with the heterogeneous circumstances that exist around the country in terms of meeting those needs that are not otherwise addressed in the first two components of what we have recommended.

Third, we would note that the draft proposes a variety of options for specifying the benefit package. We would strongly recommend that the option C approach be pursued, allow the States to determine what services, what coverages, what copayment conditions will adhere to the health benefit program established within the State.

We think the required 2-percent premium in order to pay the administrative costs of the program is a constructive idea and would urge the committee to pursue that approach. While we would prefer no matching payment, to be consistent with the basic idea of a block grant, we do find that the optional 5-percent premium provided in the bill to cover the States share of the matching cost, the 20-percent State share, makes sense. If the committee determines that some State match is desirable, then helping to finance it with an optional premium up to 5 percent would be a sensible approach.

I would also conclude that the allocation formula for the fixed budget available for this program under the block grant approach, the allocation formula provided in the bill contains good balance. But more weight to exhaustees in the formula, I believe, would be desirable.

After all, if we recognize that part of the problem can be solved by open enrollment, where you have employed family members, part of the problem can be solved by continuation coverage mandates, then what we are actually focusing on in terms of this block grant and in terms of the direct Federal money that would be provided is the extreme hardship cases: People who have been out of work for a long time and who have exhausted both their own resources and other avenues to health care coverage.

For that reason, I would urge the committee to put more than a one-quarter weight into the formula for exhaustees. That would reinforce the purpose of the grant portion of this whole package and would target the money to those States that have the largest proportional or relative share of long-term unemployed individuals and families.

Mr. Chairman, we do see a number of problems and I will quickly list those off in the draft circulated by the committee.

We believe very strongly that the AFDC-U amendments should not be included in a bill for the unemployed, and that there is no persuasive case that has been made for raising the matching rate to 80 percent in the AFDC-U program, since that is already optional with the States and should remain under the existing match arrangement.

Second, we would be very reluctant about opening up a program of temporary grants to provide health benefits for hardship cases among the unemployed to the nonunemployed with children below the poverty line.

I would suggest to the committee that this is a welfare policy problem, an income maintenance problem. It is permanent in character. And if there are shortcomings in the existing network or system of transfer payments, AFDC-U, medicaid and food stamps, that those shortcomings or gaps ought to be addressed in a separate context.

Third, I would note that the 90-day mandatory extension of employer plans is problemmatic but not fatal. I would only point out to the committee that it may encourage termination of small employer plans in the cases where firms of high employment turn overdue to seasonal character of the business that the firm is in or extremely cyclical sensitivity in some industries.

In short, you may have an ERISA problem where you are attempting to help the unemployed and you may end up encouraging the termination of plans in these limited circumstances, and penalize many more people in the process.

Finally, we would oppose the public hospital grant portion of the draft because we believe that any Federal subsidy or grant assistance should be targeted to families in need, and not to prop up institutions.

I realize that public hospitals are handling a large volume of those who are unemployed and without health care benefits. But by providing grant assistance to those individuals, it will make it possible for these hospitals to be reimbursed, and that is the avenue that we should follow in these circumstances.

So those complete my observations, Mr. Chairman. I would be very happy to take questions from members of the committee at this point.

Chairman FORD. Thank you, Mr. Stockman, for your appearance and your testimony before the subcommittees.

I think we will all agree that the unemployed who have lost their health care benefits are in a situation which they did not create. There is a problem, Mr. Stockman, we need to respond to.

I was delighted to hear you talk about the Rangel option and his proposal. I have not thoroughly looked at the Rangel proposal. I am somewhat disturbed about the block granting, how that would be implemented in the States.

But once again, we would like to thank you.

The Chair at this time will recognize Mr. Shannon.

Mr. **Shannon**. Thank you, Mr. Stockman.

Let me first say that I think we are all trying to get at the same problem. It is apparent, every time we get into the health area on a piecemeal basis, that until we address the systemic problems in the health care system there isn't going to be a good way to get at these particular groups that we might want to target health benefits to.

But one of the concerns that I have about the block grants is that the States might use the block grant payments as a way of alleviating their medicaid costs. They might just shift the funds into medicaid.

If we were to go the block grant route, how do we keep that from happening?

Mr. **Stockman**. Mr. Shannon, I think that is a good question.

I believe any bill would have to have a very strict stipulation that any grant assistance under the block grant would be secondary to all other forms of coverage or benefit available, including medicaid, private employer coverage, or other forms of health coverage that would be primary to the block grant aid.

This should be a last resort after all other avenues have been exhausted. I think you could stipulate that.

Mr. **Shannon**. As a practical matter, I think we could probably stipulate that. But it would probably be kind of difficult to put it into play, I think. Perhaps we can explore that a little bit further.

I have no further questions, Mr. Stockman. I want to thank you for your testimony.

Chairman **Ford**. Mr. Gradison.

Mr. **Gradison**. Thank you, Mr. Chairman. I too would like to thank you, Mr. Stockman. I think that we are getting closer to some kind of a resolution of this as the discussions go on.

I am concerned that whatever we do with regard to this specific problem fits into a longer term strategy of meeting the needs of the total population in terms of health care financing.

I am not sure of the implications of asking that question, but let me narrow it slightly. How would you, within the context of your recommendations, deal with the situation of those people who are employed, but have no health insurance on the job?

My understanding is that in most cases they involve relatively low-paid workers. I am concerned about, if you will, the equities or the logic of our providing special assistance for those who were employed, and who may be very short of resources to pay for health insurance now that they are unemployed, but doing nothing for those who continue to be employed, but at very low wages, and do not have health insurance on the job.

Should we, if we are willing to put some kind of mandatory requirements on the employer with regard to former employees permitting them to continue to join the group and so forth, consider as part of this some steps toward a requirement that at least some minimum health benefits, perhaps some kind of a voucher be made available as a condition of employment for anybody who works?

Mr. **Stockman**. Mr. Gradison, I think you have raised a very basic problem. It highlights one of the hesitancies that we had in the administration on this whole issue. That it is very easy to focus on the plight of the unemployed who have exhausted their income, have no access to health insurance, and there is a desire to help, and properly so. But the minute that group is targeted, you have raised questions of fairly great difficulty and importance about what do you do for similar groups who are also without health insurance coverage under the existing system.

And, of course, 20 percent of the employed population does not receive employer-provided health insurance and must pay for it with aftertax dollars, if they have those aftertax dollars available at all, at a great disadvantage.

Similarly, you have many self-employed people who are not eligible for the tax treatment that would apply in other cases, and also are at a considerable disadvantage in terms of the Tax Code inducement or incentive or subsidy.

So I don't know that we can solve that problem in this context because there seems to be some urgency of moving forward when the problem is at its peak level with 11 million people unemployed. But it does raise serious questions of equity and serious questions of failure of parallel treatment when we move forward with a program for the unemployed.

That is why I think it ought to be a block grant; it ought to be temporary, and it ought to be seen as not a permanent part of our health structure in this country, but as a temporary emergency response to a problem that we are confident will diminish steadily over time.

Then we have to go back to the basic issue of the national health strategy and how we deal with these gaps and the imbalance in the current system.

We have proposed the tax cap to finance this as a way of beginning to alleviate that inequity between employer-financed benefits, and after-tax-financed benefits in the current system.

Mr. **Gradison**. I have supported this tax cap, and find it relatively unpopular. I think part of it is that it appears to be focusing just on those fringe benefits called health insurance, which are not taxed to the employee, without looking more broadly at other fringe benefits which are similarly in whole or in part not taxed to the employee, but are deductible to the employer.

I really wondered in connection with that issue whether we might not be better off to approach it obliquely by creating a pool of tax—pardon me, a pool of fringe benefits which might, for example, include life insurance above the $50,000 part, which is not deductible, and some of the other fringe benefits that are in controversy, and then tax above the certain amount on an annual basis that the employer puts aside for fringe benefits for any individual employee. This would encourage the creation of a cafeteria-type approach not only giving the employee greater freedom and greater choices among health plans, but also allowing decisions as to where that employee wants the dollars to go such as to a very comprehensive health plan, or a more modest health plan with more going for life insurance, or longer vacations, or a company car, or whatever fringe benefits were included in this package.

I want to thank you for your testimony and thank you, Mr. Chairman.

Chairman **Ford**. Mr. Pease.

Mr. **Pease**. Thank you, Mr. Chairman. Thank you for your testimony, Dave.

I am concerned, as Mr. Gradison is, by the people who don't have hospital coverage even though they are employed. The low wage people who work for the local five and dime store and so on, self-employed people.

You seem to indicate a good deal of understanding of that problem, and sympathy for the people in that plight.

Would you expect that the administration, not in the immediate context, but in the context of the next budget cycle, would come forward with proposals to deal with that situation?

Mr. **Stockman**. Well, Mr. Pease, I don't know that I could indicate that that will occur. It is a very diffcult and tough problem, one of many that we have.

Our view, however, is that you can't solve every problem that exists at once, and therefore if the Congress and a consensus of opinion believes we must move immediately on this health benefit for the unemployed problem, I don't think that we should be slowed down or necessarily complicate the legislation that comes along by addressing acknoweldged problems, but problems which are extraneous to the issue before us.

Similarly, in the 1985 budget we are going to have a lot of things to address, one of them being how to control medicare and medicaid costs, and we are more likely to focus our proposals in that area than in a comprehensive restructuring of the combined public and private health benefit system we have in this country.

It needs to be addressed, but I don't think in the current fiscal context, 1985 is a very likely opportunity to do that.

Mr. **Pease**. What about 1986 or 1987?

Mr. **Stockman**. Well, I think that may be the relevant range of time because we know we are faced with an enormous problem of medicare long-term funding. We also know that we can't solve the medicare problem in splendid isolation. That it is built into our health payments and delivery and financing system, and all the incentives that distort things, and it might well be that the 1985-86 session of Congress will have to devote itself to the national health care issue in the context of coping with the medicare solvency problem in its own right.

Mr. **Pease**. Do you have any ideas offhand for how we would approach the problem of people who don't have—employed people who don't have—access to health care insurance? Just off the top of your head?

Mr. **Stockman**. Yes. I think the generic issue is whether you level up or level down. You can create a tax credit or voucher mechanism to provide roughly equivalent tax subsidy benefits to everyone who is excluded from the system today because their employer has not chosen to provide that kind of compensation or because they are self-employed. Or in the alternative, you could seek to cap the current tax subsidy and gradually in real terms bring it down in order to remove the inequity that way.

We have obviously chosen in the 1984 budget the second route, that it really doesn't make a great deal of sense to provide $30 billion a year in tax subsidies for one particular type of consumption; that is, of health insurance, and we would be strongly inclined to go in the second direction.

On the other hand, if that did generate revenues, it might be possible to adjust some aspects of the Tax Code for those who are excluded entirely today.

Mr. **Pease**. I was happy that you added that latter thought. While I agree that a cap on health insurance deductibility would address the inequity problem, it doesn't provide health insurance per se for the people who need it.

I guess what you are saying is that you might be able to use the revenues saved from the cap in some other way to actually put it in the hands of those who need the insurance coverage.

Do I read you correctly?

Mr. **Stockman**. Well, that would be an option to look at, but obviously we can't afford that in the current context.

You simply cannot afford to level up the system to the maximum benefits provided in the most expensive plans today.

The tax subisidy benefit can be a thousand dollars a year.

Mr. **Pease**. I note that coming out of Energy and Commerce Committee the bill before us has the support of the gentleman from Illinois, Mr. Madigan, the ranking Republican Member. So it can't be too contrary to the principles of this administration.

Would you entertain the possibility or would the President, of supporting a bill which might marry your suggestions, the ones you have made today, with the approach in the bill that came out of Energy and Commerce?

Mr. **Stockman**. Well, I recognize that in the legislative process great feats of creativity are always possible in terms of merging opposites and contradictory provisions.

But I would have to say that we have laid out two cardinal criteria, neither of which are present in the Waxman-Madigan bill.

I am not very sure that those difficulties can be overcome, and the first is that it can't be an entitlement structure.

We simply cannot accept an open-ended, unknown financial commitment in the fiscal context that we are in.

Second, any legislated bill sent to the President would have to include equal and offsetting financing within the same bill.

Now, I recognize that this couldn't be done in the Commerce Committee, but, nevertheless, this feature is absent from the Waxman proposal. It is not intended to be included and, failing that, the bill would be inadequate and unacceptable.

Mr. **Pease**. Finally, Mr. Chairman, Mr. Stockman, I am intrigued by this cardinal criterion, I guess you call it, that any new money for any new program must be self-financed essentially in the same bill.

I believe that is what you said in your testimony.

What is your thought about extending that principle to the defense budget?

Mr. **Stockman**. I knew you were going to ask that. I think what I am saying is that we have a built-in base of budget commitments now. Social security is there, and it is going to cost us so much; medicaid is there and it is going to cost us $131 billion over the next 5 years; and defense is part of that built-in base of commitments for the 5 years ahead.

We will probably obviously have to raise some revenue to finance even those existing commitments built into the 5-year budget outlook.

Therefore, if we are going to add additional programs to that built-in structure, I think we have no choice but to include the financing directly in those new initiatives, and then continue to struggle with the problem of the existing imbalance in the budget structure through the ordinary legislative process.

Chairman **Ford**. The time of the gentleman has expired.

Mr. **Pease**. Thank you.

Chairman **Ford**. Mr. Moore.

Mr. **Moore**. Thank you, Mr. Chairman.

Dave, we appreciate you being back. I think this particular issue is one that Mr. Gradison and Mr. Pease have been asking you questions on.

I really think that in our problems of health policy, financing in particular, is probably the most significant single issue we are going to face the rest of the decade. This is a small part of the problem we are dealing with this morning. Let's get it clear on the record so when my colleagues next week begin to mark up their bill we understand.

It is my understanding, from reading your testimony and what I was told you gave in your oral testimony, that you are not at all in favor of an entitlement program. I fully agree. Will you recommend a veto to the President if this committee, or Congress produces an entitlement program?

Mr. **Stockman**. Yes.

Mr. **Moore**. Thank you. You also indicated it needs to be financed. I fully agree.

In your testimony on page 22 and a moment ago in answer to a question, you indicated that a tax cap on the amount of nontaxable income to employees for health premiums paid by the employer would be one way to finance it. Am I right in understanding that?

Mr. **Stockman**. That is correct.

Mr. **Moore**. The figure that has been floated around is a figure of $2,100 for a family per year. Any premiums paid in excess of that by an employer would be taxable income to an employee.

What percent of the work force in America today, white collar, blue collar, whatever, self-employed, would be covered by that tax cap, do you know?

Mr. **Stockman**. $2,100 a year is the figure that you have—let me check that.

In that case, I think it ranges—and there are some difficulties in the numbers—but basically in the 15- to 22-percent range.

Mr. **Moore**. Only 15 to 22 percent of the American people today have policies provided by employers?

Mr. **Stockman**. Above a $175 cap. There are some questions about how many people you are measuring and the statistics aren't perfect, but I think a rule of one-fifth is basically in the ballpark if you want some notion of what share of the work force would be affected by this.

Mr. **Moore**. Would you likewise give us an indication of what the income level would roughly be of that sector of the work force? Are these the lowest paid employees in the country, some of the best paid, or what?

Mr. **Stockman**. Well, I would have to submit some data for the record. But, I think it is rather evident that these would be among the highest paid in the work force. Either those that have high collective-bargaining-achieved wages and benefits, or those who work in some of the more profitable, prosperous, emerging industries in the country.

So they are going to generally have a much higher than median or average wage.

Mr. **Moore**. We get the impression we are talking about union employees who, through collective bargaining, have been able to get this.

I understand there is only one union in the country, is that right, one or two that have benefits that are in this range of $2,100 or more?

Mr. **Stockman**. Well, I am not sure on that. Again, we would provide it for the record, but the obvious cases are the UAW contract, and I believe the steelworkers' contract. But many of the 15- or 20-percent impact are nonunion. The idea that somehow this is targeted as union negotiated health benefits is entirely erroneous. It would be a minority share of the total impact.

Mr. **Moore**. As a matter of fact, corporate executives, people that work in banks and whatever, are some of the same people who would have these kinds of benefits, am I right?

Mr. **Stockman**. That would be right.

Mr. **Moore**. If indexing remains in the law which goes into effect in January 1, 1985, this cap would likewise be indexed, am I correct?

Mr. **Stockman**. I would have to check the provisions. I do believe the indexing mechanism applies not only to the taxable or brackets, but also to the personal exemption and standard deduction and whether it would apply to this or not, I am not sure.

You could easily write it that way.

Mr. **Moore**. In addition to being a way to provide financing for this program that we are currently having the hearing on, isn't there a positive benefit we get in the marketplace in terms of stabilization of the escalating health care cost through a tax cap?

Can you comment on that?

Mr. **Stockman**. Yes, and that is the basic reason why it was proposed in the January budget. The revenue yield is secondary or incidental. The primary purpose was as an element in our overall health cost containment package. We have too much first dollar coverage. We have too little copayment in the existing structure of health insurance.

Those are powerful forces for excesisve utilization, for lack of efficiency in the system. So to the degree that we cap the tax excludability of dollars going into those benefit packages, we will see restructuring to live within the cap that will have a positive effect on health costs and health costs containment.

Mr. **Moore**. For everybody?

Mr. **Stockman**. For everybody.

Mr. **Moore**. Mr. Stockman, one last question. Along those same lines, isn't it true that for $2,100 you can buy full catastrophic coverage and full major medical coverage, and almost, almost full coverage, for $2,100 for a family?

Mr. **Stockman**. I think that is correct. I would note that the average premium value is $114 a month, or well less than $2,100 a year, in the existing structure of employer benefits throughout the system. And that provides a fairly broad level of benefits.

Now when you go to the $175 level, you are talking about major coverage on all of the components that people normally think of in terms of health care protection.

Mr. **Moore**. So a tax cap of $2,100 would not be leaving anybody in America with a choice of paying taxes or not having health insurance. Essentially they would have more health insurance than most people have today and could really afford.

Mr. **Stockman**. That is correct, but over time people would have to make some choices about where they want to put their insurance dollars, not catastrophic, or first dollar, into psychiatric, or something else. We believe inducing that process of making choices is going to be critical in the long run to getting a more efficient health care delivery system.

Mr. **Moore**. Thank you. Thank you, Mr. Chairman.

Chairman **Ford**. Mr. Moore, did you support the cap yesterday before the Ways and Means Committee on the third year $750?

Mr. **Moore**. I think we are talking about different caps.

Chairman **Ford**. Oh. That is for the welfare, that 15 percent, I didn't know the gentleman—Mr. Pease?

Mr. **Pease**. I was struck, too, in the colloquy between the gentleman from Louisiana and Mr. Stockman that this cap on deductibility of insurance premiums is attractive because it would affect less than 20 percent of the population and it would affect mostly high-income people. That seems to describe the cap on the third year of the tax cut almost to a tee.

Mr. **Moore**. If the gentleman would yield, it describes it from the way you looked at it. I think we had a different opinion of that yesterday.

Chairman **Ford**. Mr. Stockman, we would like to thank you very much for your appearance before the subcommittee.

Mr. **Stockman**. Thank you.

Chairman **Ford**. Thank you. The committee will recognize from the AFL–CIO, Mr. Bert Seidman and Mr. Robert McGlotten.

STATEMENT OF BERT SEIDMAN, DIRECTOR, DEPARTMENT OF SOCIAL SECURITY, AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS, ACCOMPANIED BY ROBERT McGLOTTEN, ASSOCIATE DIRECTOR, DEPARTMENT OF LEGISLATION; AND KAREN IGNASNI ASSISTANT DIRECTOR

Mr. **Seidman**. Thank you, Mr. Chairman.

Chairman **Ford**. Mr. Seidman, the Chair will recognize you first, then Mr. McGlotten.

Mr. **Seidman**. Thank you, Mr. Chairman.

I am Bert Seidman, director of the department of social security of AFL-CIO. With me, to my right, is Robert McGlotten, associate director of our legislative department. To my left, Karen Ignasni assistant director of the social security department.

Mr. Chairman, the AFL-CIO is pleased to have this opportunity to present its views on H.R. 3021.

Organized labor strongly supports this legislation and hopes it will soon be considered by the full House. Its enactment is long overdue. If the subcommittees which you chair feel a need to make changes in the bill, we hope that they will be limited so that the bill can be reported expeditiously to the floor.

Mr. Chairman, I would like to emphasize the urgency of enacting this legislation at the earliest possible moment. It is true that there has been a very slight decline in the total rate of unemployment as reported by the BLS. But the proportion of the unemployed who are the long-term jobless has increased. Last month, the average length of unemployment was over 20 weeks. That is the average. One quarter of those unemployed are unemployed over 27 weeks.

You can see, therefore, that the proportion of unemployment among the long-term jobless, those least likely to have any health care coverage whatsoever, is increasing, and not going down. We, therefore, urge the House to act now and provide sufficient funds so that needed care is given. A token program is not enough. The legislation should lend itself to implementation as soon as possible after enactment.

Mr. Chairman, the AFL-CIO was very pleased with the bipartisan support for H.R. 3021 in the Energy and Commerce Committee. We hope a similar situation will prevail in your committee. Unemployment is often no longer a short, temporary setback for workers. The figures demonstrate this amply. It is resulting in longer periods of joblessness, greater exhaustion of financial reserves, and frequently permanent, and I stress that, permanent economic, social, emotional, and physical health problems.

Despite years of effort the United States has no national health program to provide jobless workers access to health services. In this country, access to health care services is contingent upon whether you work, where you work, or how much you can pay.

The AFL-CIO has developed eight principles which we believe should be incorporated into legislation to provide health care for the unemployed. They are:

First, the program must not concentrate exclusively on catastrophic care. If the program is to be cost effective and meet the health care needs of the unemployed, preventive care and diagnostic services must be offered. Prenatal and postpartum care are especially important.

Second, the program must use a cost-effective reimbursement mechanism, such as negotiating per capita agreements with providers.

Third, workers who have exhausted unemployment compensation must be eligible for services.

Fourth, public employees must be eligible for the benefits for which other employees are eligible.

Fifth, cost sharing on the part of the unemployed beneficiaries by definition of either no income at all or very reduced income and should be limited to nominal amounts required under medicaid.

Sixth, providers who participate in the program must accept assignment.

Seventh, a grant program should be created for public hospitals.

Eighth, funding for the programs must be adequately based on levels of unemployment. The so-called insured unemployment rate simply does not measure true unemployment. When you see States like Michigan and Ohio and Indiana with very, very high levels of unemployment triggering off from extended benefits it is clear that this is a totally artificial rate which does not measure the true extent of unemployment.

In our opinion H.R. 3021 meets all of our requirements and contains an important provision which would create a countercyclical grant program for facilities, including public hospitals, which are the providers of last resort for the elderly, the poor and those without health care protection.

Before concluding our statement, Mr. Chairman, I would like to comment on proposals to finance health care for the unemployed by placing a limit on the amount of tax-free employer contributions to health care. These are two totally different issues that should not be joined. We must not try to rob Peter to pay Paul. Congress must move quickly to provide access to health care for the unemployed. There is widespread support for such a program. The fact that this is a bipartisan bill sponsored by the two ranking members of the Health Committee, Subcommittee of the Energy and Commerce Committee, is a clear indication of that.

We urge the Congress to move quickly to provide access to health care for the unemployed. Now, on the other hand there is widespread opposition to placing an arbitrary limit on tax-free employer contributions for health insurance. We are joined by organizations with which we do not often see eye to eye, including as I understand it, the Chamber of Commerce of the United States and National Association of Manufacturers. And we don't generally agree on very many issues. But on this one, employers and workers are united in feeling that this is the wrong way to go.

We strongly urge that Congress not seek to prevent passage of a health care program for the unemployed by holding it hostage to extracting approval of a tax on health care employer payments.

Today, the ravages of recession have cut deeply into the lives of millions who have never been jobless, who have never been without health care protection. We are discussing the restoration of at least a minimal level of health care benefits to people who have lost their health care coverage immediately or soon after they lose their jobs, through no fault of their own. I don't think anybody really has measured the full extent of this. We think there are millions of such people.

We urge that this committee now minister to the victims, the wounded of our national economy's breakdown by acting expeditiously on H.R. 3021. Of course my colleagues and I will be glad to answer any questions members of the subcommittees may have.

Thank you, Mr. Chairman.

[The prepared statement follows:]

STATEMENT OF BERT SEIDMAN, DIRECTOR, DEPARTMENT OF SOCIAL SECURITY, AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS

The AFL-CIO is pleased to have this opportunity to present its views on H.R. 3021.

Organized labor strongly supports this legislation and hopes it will soon be considered by the full House. Its enactment is long past overdue. If the Subcommittees which you chair feel a need to make changes in the bill, we hope that they will be limited so that the bill can be reported expeditiously to the floor.

The AFL-CIO was very pleased with the bipartisan support for H.R. 3021 in the Energy and Commerce Committee. We hope a similar situation will prevail in your Committee.

It is crucial that legislation be brought to the floor as soon as possible. For unemployment is often no longer a short, temporary setback for workers, but is resulting in longer periods of joblessness, greater exhaustion of financial reserves and, frequently, permanent economic, social, emotional and physical health problems. Despite years of effort the United States has no national health program to provide jobless workers access to health services. In this country, access to health care services is contingent upon whether you work, where you work, or how much you can pay.

The AFL-CIO has developed eight principles which we believe should be incorporated into legislation to provide health care for the unemployed. They are:

1. The program must not concentrate exclusively on catastrophic care. If the program is to be cost-effective and meet the health care needs of the unemployed, preventive care and diagnostic services must be offered. Prenatal and postpartum care are especially important.
2. The program must use cost-effective reimbursement mechanisms, such as negotiating per capita agreements with providers.
3. Workers who have exhausted unemployment compensation must be eligible for services.
4. Public employees must be eligible for the benefits for which other employees are eligible.
5. Cost-sharing on the part of the unemployed beneficiaries should be limited to nominal amounts required under Medicaid.
6. Providers who participate in the program must accept assignment.
7. A grant program should be created for public hospitals.
8. Funding for the programs must be adequately based on levels of unemployment.

H.R. 3021 meets all of our requirements and contains an important provision which would create a countercyclical grant program for facilities, including public hospitals, which are the providers of last resort for the elderly, the poor and those without health care protection.

Before concluding our statement, Mr. Chairman, I would like to comment on proposals to finance health care for the unemployed by placing a limit on the amount of tax-free employer contributions to health care. These are two totally different issues that should not be joined. We must not try to rob Peter to pay Paul. Congress must move quickly to provide access to health care for the unemployed. There is widespread support for such a program. On the other hand there is widespread opposition to placing an arbitrary limit on tax-free employer contributions for health insurance. We strongly urge that Congress not seek to prevent passage of a health care program for the unemployed by holding it hostage to extracting approval of a tax on health care employer payments.

Today, the ravages of recession have cut deeply into the lives of millions who have never been jobless, who have never been without health care protection. The ideal solution to this problem is a recovered economy with jobs and the benefit protection that usually accompanies that job. In the meantime, we must minister to the victims, the wounded of our national economy's breakdown. As a major step to that end, we urge you to act expeditiously on H.R. 3021.

Chairman FORD. Thank you, Mr. Seidman.

On the last page of your testimony you talked about health care for the unemployed and not tying it into the tax-free employer contribution for health insurance. Mr. Stockman and the administration has talked about some means of financing the program. If you are saying these are two separate issues, do you have any recommendations as to how we could finance the proposal that is before the committee now?

Mr. SEIDMAN. I would like to ask Mr. McGlotten to possibly supplement what I have to say. But the AFL-CIO has a program which provides for additional ways of securing revenue and at the same time provides for what we consider to be essential expenditure programs for jobs and to get the economy moving again. One of those programs is health care for the unemployed.

Second, the House has passed a budget which includes funds which would make possible the kind of program which is contained in H.R. 3021. And those are the ways that we think that the program should be financed. I dont know if Mr. McGlotten wants to add to what I have had to say.

Chairman FORD. Mr. McGlotten.

Mr. MCGLOTTEN. Mr. Chairman, I would like to add that the AFL-CIO back in 1981 proposed a $700 cap. The committee voted out that cap yesterday. That cap will raise revenues of about $6 billion. The question of health care for the unemployed is $2.3 billion. Clearly there is additional money left over. We believe that the whole question of the cap the way the administration has proposed it will really contain no health care cost. I mean even the numbers don't even bear out that fact. If you are only talking about 15 percent of the people being affected, how is that going to control the cost of hospital care when the other 85 percent are still left at the whims of the doctor?

We believe that a comprehensive cost containment program is essential but it is not a true tax cap that will get you that cost containment to hold down hospital costs.

Chairman FORD. Mr. Seidman, you indicate that the Chamber of Commerce, AFL-CIO and you mentioned another organization. What was the name of that organization?

Mr. SEIDMAN. I can't speak for other organizations, but it is my recollection that the National Association of Manufacturers, certainly the Health Insurance Association of America, the Blue Cross-Blue Shield, the National Council of Senior Citizens, there is a whole broad range of organizations who don't usually agree on very many things——

Chairman FORD. Sounds like a pretty healthy coalition to me, then.

Mr. SEIDMAN. We think it is a very unusual coalition. We had them all in our building the other day. They are people who don't often come to the AFL-CIO.

Chairman FORD. Mr. Pease.

Mr. PEASE. Thank you, Mr. Chairman.

Mr. Seidman, Mr. McGlotten. What do you say when David Stockman comes before us and says categorically that he will recommend a veto of this Energy and Commerce bill if we report it out and pass it? Does that put you in a position of winding up with a good bill and no law, and therefore no service to unemployed workers? Or do you think it is possible to override a veto?

Mr. SEIDMAN. We think in the first place that the fact that there is bipartisan support of legislation for health care for the unemployed in both Houses of Congress, there are various proposals, and we think this is the best proposal by far, which is before the Congress at the present time. But there is bipartisan support. Mr. Stockman acknowledged that for large numbers of people this is a very serious problem. We hope that the President will recognize it as such and therefore we would hope that even if Mr. Stockman makes such a recommendation, that the Secretary of Health and Human Services, that leading members of the President's party in both Houses of Congress will strongly urge him to sign such legislation. And we would hope that he will.

In any case we do not think that that should in any way deter your committee from reporting out as quickly as possible this urgently needed legislation.

Mr. **Pease**. Do you accept Mr. Stockman's assertions that about 5 million, roughly half of the people who are unemployed now, have access to health insurance through other members of the family?

Mr. **Seidman**. I don't think that there are any good figures on this. But I would like to point out that the legislation which you have before you, the bill that you have before you, and we certainly advocate, that any coverage which becomes available as a result of this legislation should be secondary to whatever other coverage people have.

Second, we strongly support what he apparently supports also. And that is that if health care coverage is available through a spouse, there should be a provision in the bill so that that becomes available. We want to narrow down this as much as we can so that it is meeting the needs of people who do not have health care coverage. We don't want to give it as additional coverage to people who do have it. But Mr. Stockman himself pointed out that if you didn't take account of the duplicative coverage, and we think that there is some, and if you provided comprehensive care to all of the people who are unemployed and their families, you would have a program that costs $18 billion.

Well, we are not talking about a program that costs $18 billion. We are talking about a program which allows for only $2.7 billion. Clearly there will not be room with that kind of money to duplicate coverage. And we are not in favor of duplicating coverage.

Mr. **Pease**. Thank you.

Mr. Gradison.

Mr. **Gradison**. Thank you, Mr. Chairman. Mr. Chairman, I would just like to make an observation, that yesterday afternoon in this very room we had a long discussion about the tax cap. The argument which was used in favor of it was that it would permit us to reduce the deficit by the amount of the tax cap. Less than 24 hours have passed. Now we have witnesses for whom I have the highest respect and who understandably are here in behalf of a very important cause, but we have witnesses already before us with ideas on how to spend a substantial amount of that additional revenue which would stay in the Treasury as a result of the tax cap and who cite that action as a source of funds.

I just think it is illuminating in light of some of the arguments we had yesterday.

Thank you, Mr. Chairman.

Mr. **Pease**. Mr. Moore.

Mr. **Moore**. Thank you, Mr. Chairman.

I certainly have great sympathy for the problem we have and compliment Mr. Seidman for his testimony and concern in trying to keep these policies as lean as we can. I think we are still calling for full diagnostic coverage, that sort of thing, which may not be within the terminology as being as lean as we could get it. I was the author, if the Chair remembers, of an amendment that is part of the law now that allows these programs already, voluntarily. So I have concern for this. I would like to follow up on the financing. I think that is a problem. I don't think we are responsible today to pass programs without ways of financing them.

Earlier in the testimony I think, Mr. Seidman, you mentioned the House passed budget calls for $30 billion in taxes. The Senate calls for less. We are just guessing what is going to be the final budget resolution, but I fully acknowledge there will probably be somewhere in that budget resolution, if it ever becomes adopted and that is another question, between $8 and $12 billion, more than enough to pay for this program.

But specifically that doesn't say what tax we raise to do it. I think what was done yesterday isn't going anywhere and everybody knows that. That is not going to become law. Everybody understands that. So I don't think talking about a cap on the third-year tax cut is really talking about anything meaningful. I don't think anybody takes that seriously. It is a political exercise. Everybody knows that. So let us talk turkey. Tell me what tax we should raise to raise the $2 billion for this program.

Mr. **Seidman**. Congressman, I realized when I heard the line of questioning of Mr. Stockman a few moments ago that even though this was not in my usual area of responsibility, I should have brought with me the AFL-CIO program for increasing revenues in order to pay for essential programs. But we will be very glad to make that available to the subcommittee. We will submit that information.

[The information follows:]

AFL-CIO TAX PROPOSALS

[In billions of dollars]

	Fiscal year			
	1984	1985	1986	1984-86
$700 cap-third year	6.0	6.9	7.4	20.3
Repeal indexing	0.0	8.9	23.4	32.3
Trim "savings" exclusions	0.6	1.7	3.7	6.0
Phase down capital gains exclusions	2.5	5.6	8.1	16.2
Scale back estate and gift tax exclusions	1.6	2.1	2.8	6.5
Foreign tax:				
DISC	2.0	3.0	3.0	8.0
Deferral	6.0	6.6	7.1	19.7
Foreign tax credit	6.5	7.1	7.4	21.0
Investment tax credit:				
Depreciation basis adjustment	1.3	2.4	4.1	7.8
Reduce 10 percent to 7 percent	5.6	7.1	8.2	20.9
Limit graduated rates to small corporations	1.9	2.0	2.0	5.9
Oil and gas depletion and expensing of drilling costs	7.2	8.0	9.0	24.2
Total	41.2	61.4	86.2	188.8

Mr. MOORE. I appreciate that. Again, this question is likewise maybe beyond what you have before you. If you don't know it, I appreciate you likewise sending that to us, and would ask the Chair to make the record open to receive both points of requested information. Can you tell me what percent of union membership and how many unions currently have benefits paid by their employer for health insurance that exceeds $2,100 a year.

Mr. SEIDMAN. I am not sure we are able to provide such information. That kind of information in the past was collected by the Bureau of Labor Statistics which has had its funds reduced. I am not sure they are providing that kind of information now but we do know that there are a considerable number of unions that have negotiated such programs. And negotiations, as you know, does not take place exclusively on a national basis. For the most part it takes place on a local basis, and you would have to look at the 60,000 collective bargaining contracts to be able to determine what percentage that would be.

But where you have an effort to obtain comprehensive coverage, and we think comprehensive coverage is the most cost effective kind of coverage that you can have, where you have large numbers of older workers in the bargaining unit, where you have large numbers of handicapped workers in the bargaining unit, where you have areas which through no fault of the workers are high cost areas, it is in those situations that you are most likely to have collectively bargained health care programs which would exceed those limits.

Mr. MOORE. If you have any information we would appreciate it.

I have been led to believe from the figures I have seen so far, that is why I asked you, as you might be a better source than some I have seen, that there are very few unions that have negotiated contracts this high.

Second, when you begin to look at what they are negotiating, it is first dollar coverage, which every single expert we have heard from has indicated that is not health efficient or cost effective.

Mr. SEIDMAN. I know many experts who feel it is the most cost effective way. We are strongly in favor of first dollar coverage because we think that any financial barriers to obtaining health care at the earliest possible moment means that you put the stress not on preventive care and early diagnosis, which is the stage of health care which is the least expensive, but you don't catch the problem until later on when it is more acute, and people have to be——

Mr. MOORE. We are talking about different things.

Mr. SEIDMAN [continuing]. In a hospital and it costs a great deal.

Mr. MOORE. We are talking about two different things. I fully agree——

Mr. SEIDMAN. If you look at the Canadian experience where there is no cost sharing, they have been able to hold their health care costs down for years now, since the national health insurance program came——

Mr. MOORE. That is where we differ——

Mr. SEIDMAN [continuing]. To 7 percent of their gross national product while ours has been going up and up and up. We think one of the major reasons for that is because of the emphasis on care in the hospital, rather than at the early stages of illness.

Mr. **Moore**. Then you don't recognize those experts who say first dollar coverage likewise has no consideration for cost on anybody's part. The patient has no reason, the doctor has no reason, the hospital doesn't care because it is all paid for, the insurance carrier doesn't care and the employer doesn't care and it is paid for by taxes.

Mr. **Seidman**. We think care ought to be provided on the basis of medical needs, not on the basis of the financial resources of the individuals. It has been shown over and over again that when people, if they can afford it, when people can't obtain first dollar coverage, they get the supplementary coverage which permits them to have it. All you have to do is look at the medicare experience to see what happens. We are not going to be able to cut out first dollar coverage for everybody.

What we do is we cut out first dollar coverage for the people who can't afford it. But first dollar coverage is not what we are talking about anyway because I don't know of very many, even on the best contracts far above the limits that you are talking about, you still have a situation where workers and their families are paying a large proportion of their total health care costs out of their own pockets. So that they are concerned about health care costs.

Unions are concerned about health care costs, employers are concerned about health care costs. This comes up in all our negotiations. There is nobody in this country any more that I know anything about who is not very much concerned with holding down health care costs and is acting in the health care economy on that basis.

Mr. **Moore**. I beg to differ though. That gets to the point that you have always been consistent in supporting national health insurance and Government regulations and financing to put that kind of program on the American people and it has never passed, and I hope it never will. Many of us are looking at the marketplace and any time you have a program like you are talking about your idea is to see to it that the employee or patient doesn't have to pay any of it. The problem is somebody is paying it. That is why health costs are 10 percent of GNP. It is not going down unless we do something like you are talking about, to have the government come in and set everybody's prices.

Mr. **Seidman**. We don't like many people who like to take time off from work to go in doctors' offices and be docked from their pay. We don't know many people who like to be in the hospital when nobody is at home taking care of their children. We think this is all a myth. The responsibility for the costs of health care should lie primarily with the providers of care. That is why we are in favor of regulating the reimbursement to providers of care.

Mr. **Pease**. The time of the gentleman has expired. Mr. Shannon.

Mr. **Shannon**. Let me comment on some of the things my colleague from Louisiana has said in his dialog to you. It seems to me the big difference between health insurance and other forms of insurance is that, with the other forms of insurance, you might think the chances are pretty good that your car won't be stolen or that somebody is going to throw a rock through your window or your house is going to burn down.

But it is inevitable that, sooner or later, we all go to the doctor for something. We all get some health care. So while there is a kind of surface appeal to the notion that if we could shift away from first dollar coverage to different types of coverage after first dollar coverage, we might change peoples' behavior, I just agree with you completely that people are still going to want to go out and get that first dollar coverage knowing that sooner or later they are going to have to use it and that it is inevitable that they are going to have to use it. So I don't really buy the notion that we can include these kinds of economic incentives that have been suggested affect changes in the way in which the health care economy works, that is fair. I just don't think it is going to work out fairly.

We have already got millions of Americans who are uncovered or undercovered by health insurance. I am afraid we are just going to make that problem worse if we go to that kind of system. I just want you to know I share your views on that. We haven't got any easy solutions to this problem, as you are well aware, and as the gentleman from Louisiana is well aware.

But I don't think we are going to come closer to solving the problem by increasing the costs of health care for people who are already in need and don't have adequate access to health care.

Mr. **Seidman**. We certainly agree with you, Congressman Shannon. Of course, as you know, we support the bill that you have just introduced which takes a comprehensive approach to the whole question of trying to hold down health care costs in terms of covering all payers and covering all forms of care. We think that is the approach that should be used rather than one that puts the whole burden on the sick patient.

Mr. **Shannon**. I hope we can see some action on that legislation. I do want to thank you for your testimony today as well.

Mr. **Pease**. Thank you.

Mr. McGlotten, do you have a separate statement to make?

Mr. **McGlotten**. No.

Mr. **Pease**. In that event, thank you very much, Mr. Seidman and Mr. McGlotten, we appreciate your testimony.

Mr. **Seidman**. Thank you.

Mr. **Pease**. The next panel will be from the National Governors' Association and the National Association of Counties. The subcommittee would like to recognize at this time the National Governors' Association, Mr. Raymond C. Scheppach, executive director, and Mr. Richard E. Curtis, along with Mrs. Ann Klinger.

The chair will recognize you in that order, please.

STATEMENT OF RAYMOND C. SCHEPPACH, EXECUTIVE DIRECTOR, NATIONAL GOVERNORS' ASSOCIATION

Mr. **Scheppach**. Thank you, Mr. Chairman.

I would like to enter my full statement in the record and summarize it briefly.

Mr. **Ford**. Without objection, it will be made part of the record.

Mr. **Scheppach**. First I would like to make several general comments about health insurance for the employed, second, I would like to summarize some alternatives which we think can meet both the State and Federal goals for the legislation; and third, some final comments on the committee circulated bill.

First, Mr. Chairman, Governors are strongly opposed to any federally mandated personal entitlement program, particularly one in the health care area, due to our inability to accurately project future costs. Both the States and Federal Government are hard pressed to meet existing commitments in medicare, medicaid and other critical programs. When the costs of entitlement programs exceed expected levels, the States have to cut other programs to offset these costs. This creates a significant amount of inefficiency and description in State budgeting systems.

Second, Mr. Chairman, due to the very difficult financial picture currently faced by the States, they are opposed to any program that requires them to provide additional resources. Most states currently operate on a July to July fiscal year basis, and are in the process of finalizing their particular budgets for fiscal year 1984.

If any program is adopted now that requires additional funds, States have to do one of two things: raise taxes or go back and cut other programs. During the last 2 to 3 years due to the recession and Federal budget cuts, States have had exceptional financial problems. In 1983 47 States already have made major budget reductions. To offset substantial State revenue reductions, 21 States adopted tax increases in 1982 and a similar number of States have done so in 1983.

Just in the last several months, five States have raised corporate taxes; six States, sales taxes. Several others have had income tax increases. Many of these State tax increases have been very large. In 1983, Ohio had to raise their income tax by 90 percent, Michigan by 38 percent; several States had to raise their sales taxes from 3 to 4 percent, or a 33 percent increase.

Because of the fiscal condition of the States, Governors would oppose any State share of program costs unless funds could be obtained through beneficiary premiums and/or copayments.

Third, a program that relies on State management should be structured to give States latitude to manage in the most cost effective manner. They should be able to target resources on individuals with the greatest need and to use whatever financing mechanisms and administration mechanisms they choose.

Therefore, the Governors' Association would oppose the Commerce Committee reported bill as it is currently constructed. We do think, however, that there is an alternative approach which may be acceptable to both States and to the Federal Government. With respect to eligibility, we realize that we do not want to impoverish people before they are eligible for this particular program.

However, it seems appropriate to have some income test. As a middle ground, the committee could exempt the cost of loan payments on houses and cars and other major purchases, and allow States to then look at remaining income as an income test.

With respect to the benefit package, again it seems sensible for the Federal Government to specify which services are appropriate, but let the States determine the scope and duration of those benefits. With respect to cost sharing, we believe the Federal Government should only set upper limits on the percent of unemployment compensation income that can be expended on premiums, deductibles and copayments, and allow States flexibility within those particular limits.

Turning to the committee circulated proposal, I would say, in general, that we would be more supportive of this approach bill than the bill reported out of the Commerce Committee. First, it allows targeting of benefits on individuals with the greatest need. It gives us substantial flexibility in the use of administrative mechanisms, and in the structure of benefit payments.

There are, however, several problems with the bill. We do not known the size of the population that you entitle. The costs of covering that population could be very, very large over time.

Second, we believe the population that you are entitling may in fact be distributed very differently than the allocation of the funds, which is based only on general unemployment. In particular, the entitled population may be heavily concentrated in low income rural States, which differs considerably from the allocation of funds that you have in the bill.

We also have problems with the required State share, although we haven't had time to run the numbers. The uniform 20-percent State share is too high. We realize some of that can be met by the premium payments, but perhaps not enough to cover that total.

In summary, Mr. Chairman, we find that the structure of this committee's circulated bill is preferable to the Energy and Commerce Committee bill. We would like to work with you to make some changes in that particular bill.

Thank you, Mr. Chairman.

[The prepared statement follows:]

STATEMENT OF RAYMOND C. SCHEPPACH, EXECUTIVE DIRECTOR, NATIONAL GOVERNORS' ASSOCIATION

MR. CHAIRMAN, the National Governors' Association appreciates the opportunity to present our views with respect to health benefits for the unemployed and H.R. 3021, the Energy and Commerce Committee reported bill. In general, the nation's Governors have the following concerns regarding this critical issue:

- It is essential that the costs of any program that Congress enacts be predictable and affordable. Neither the the states nor the federal government can afford a new personal entitlement program, particularly a new health care financing program that entitles a large number of persons regardless of individual resources. It is impossible to accurately predict the costs of such a program. This is not acceptable given the current reality that the Congress and the states are already extraordinarily hard-pressed to meet existing commitments in Medicare, Medicaid and other critical programs. New revenues should be enacted to support a health benefit program for the unemployed so that the federal deficit problem is not further exacerbated.
- While a large number of unemployed persons do not have health insurance coverage, the states are currently in such a difficult fiscal situation that they do not have resources available for such a program. Most states operate on a July to July fiscal year and most are currently finalizing their budgets in the face of continuing declines in state revenues. If they had to contribute to such a program they would have to either raise taxes or reduce other state expenditures since they cannot deficit finance. Many have already enacted politically unpopular tax increases just to sustain programs at already reduced levels. States with significant unemployment are also those least able to generate monies to address this problem. The federal government is, therefore,

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the appropriate level of government to provide health care services for persons with no other coverage.

A health benefits program for the unemployed that relies on state management should be structured to give states the latitude to manage it in the most efficient and timely manner possible given individual state circumstances. They should be able to target resources on individuals with the greatest medical and/or financial need, to use whatever cost effective financing and reimbursement mechanisms they choose, and to use alternative administrative mechanisms to accomplish program objectives.

I will now turn to a fuller discussion of our views regarding the structure of H.R. 3021, and to present an alternative approach which we think can more effectively provide health services for the unemployed.

Background

The current recession has resulted in significant hardships for millions of unemployed Americans. Recent studies indicate that the stress of unemployment can often result in an increased need for health care. However, approximately 10 million jobless individuals and their dependents have lost health insurance coverage because of unemployment, according to recent CBO estimates. While policies regarding extensions and conversions of employer-provided health benefits can afford protection to individuals who become unemployed in the future, such approaches cannot adequately afford protection to uninsured individuals who are already unemployed.

Those states with the largest numbers of unemployed individuals have realized the greatest deterioration in their state revenue base. Further, their health delivery systems have often reached the limits of their financial ability to serve unemployed individuals without compensation. The states are unable to control the major factors that influence employment or the economy. Federal policies such as monetary, budgetary, tax and trade policies are the principal public sector tools that can drive the economy. For these reasons, the federal government is the appropriate level of government to provide for the medical care needs of currently unemployed persons with no other coverage. The Congress should, however, enact new federal revenues to support such a program so that it does not exacerbate the federal deficit. Otherwise, economic recovery and long-term economic growth will be further impeded by interest rate increases driven by federal borrowing.

The Entitlement Problem

We urge this committee not to report H.R. 3021 in its current form. Neither the federal government nor the states can afford a new personal entitlement program, particularly a new health care financing program that entitles a large number of persons to uniform benefits regardless of individual need.

H.R. 3021 precludes states from adequately providing for those individuals in greatest need, while requiring coverage of individuals who needs are far less severe. Those individuals with chronic conditions or catastrophic costs would be limited to a prescribed limit of 9 hospital days or 10 physician visits, even though they have a critical need for substantially greater coverage.

We believe that a prescribed program structure of this nature is unwise because none of us have an adequate information base regarding, or experience with, a health financing program for this population. We therefore do not know what the health service needs of this population are, precisely how many of these individuals would be eligible for benefits under H.R. 3021, what percentage of these eligible individuals would actually enroll as beneficiaries, and what the service utilization rate would be for those enrolled. For these reasons, if the Congress desires to put a priority on a specific unemployed subpopulation, we would urge you to provide that members of that subpopulation be covered before other individuals rather than entitle the entire subpopulation.

Although the state run program in H.R. 3021 would be sunseted in three years, the program structure and requirements are in many respects patterned after Medicaid. We believe that a temporary program that is meant to address immediate needs caused by extraordinarily high current unemployment rates should afford states substantially more flexibility than a permanent federal entitlement program for the nation's poor. Further, it is not sensible to impose a rigid uniform program nationally when we have no experience with a health care program for this population. The states should be in a position to design and modify such a program based upon actual state circumstances and experience with the program as it is implemented.

State Fiscal Problems

The states are already extraordinarily hard-pressed to meet existing commitments such as means-tested income support and health programs. NGA, therefore, opposes any requirements for state fund expenditures. If the Congress insists on matching funds, NGA would urge a compromise approach wherein the levels are low enough that states could meet such requirements through beneficiary premium revenues and program savings accruing from beneficiary cost-sharing requirements, rather than state funds.

Any new state cost burden must be examined in the context of the overall fiscal condition of the states. In 1982 and early 1983, the states' fiscal condition was the worst it has been in recent memory. The days of unused reserve fiscal capacity at the state level are gone and are not likely to return soon. Data recently collected by NGA and NASBO indicates that, overall state balances, which were none too strong at the beginning of the fiscal year, will continue to drop. Aggregate balances are expected to total $291 million in 1983, or .2 percent of general fund expenditures (compared to 9 pecent in 1980, 5.6 percent in 1981 and 3 percent in 1982). When the Texas balance is disregarded, the aggregate balance becomes negative. Twenty-seven states expect negative 1983 balances or balances of less than 1 percent of current year expenditures. Six states are still facing deficits. These states have been backed to the fiscal wall, and some have taken extraordinary measures so that they can carry over their deficit into the next fiscal year. This is not a permanent solution, and political tradition and legal requirements at the state level will not permit the accumulation of a continuing state deficit.

In 1983, 47 states took steps to restrict expenditures. Most frequently used were hiring limits (42 states), program cuts (37 states), restricted out of state travel (32 states), and temporary or permanent revenue increases (32 states). States expect to rely on similar actions for needed savings in 1984.

The most important cause of these state fiscal problems is the recession. On the revenue side, a recession reduces sales, income, and other tax receipts below their expected level. With respect to expenditures, a serious recession increases the demand for social services and income support programs. While nationally the economy is just beginning to show some signes of an upturn, the states are only guardedly optimistic. They currently project revenue growth of 4 percent between 1982 and 1983. This may be somewhat conservative, but very clearly we are not back to the big growth years of the late 1960's and early 1970's. We do not have, and do not project having, reserve fiscal capacity in the near future.

As for the long range outlook, the states face the same political climate that you face. The public wants to keep its overall tax burden down, even if the consequence is reduced services. We, as you, have been forced to further increase some tax rates just to keep current programs in place. Twenty-one states increased taxes during 1982. In that year, 7 states raised their personal income taxes, 4 raised their sales taxes, 4 increased their corporate income taxes, and 9 raised their motor fuel taxes. For 1983, the states enacted permanent revenue increases and 24 have enacted or proposed temporary taxes. So far, through April 1, 5 states have raised their personal income taxes, 2 states have raised their corporate income taxes, 6 states have raised their sales taxes (one more has put in place an increase on a contingency basis), 8 states have raised their motor fuel taxes, and 3 states have raised their cigarette taxes. Many of the tax increases enacted by states have been large. Using examples from 1983, Ohio's income tax rate was permanently raised 90 percent beginning March 1, Michigan's income tax rate was increased 38 percent retroactive to January 1983, and the sales tax rates in Iowa and North Dakota were permanently raised from 3 to 4 percent. Such tax increases were essential to sustain state programs at already reduced levels.

Given the fiscal condition of the states, a program to provide health services for the unemployed must be a managable and affordable structure. States must have the ability to target available resources on those individuals with the greatest medical and/or financial need. States would, therefore, have the authority to base eligibility on an individual's income and assets as well as on the level of medical expenses personally incurred by that individual. In addition, states should be able to determine service coverage as well as the amount, duration and scope of services available for identified subpopulations. Further, state exceptions to service limits for reasons of medical necessity should be allowed.

Cost Effectiveness

States should also have complete authority to use expeditious, cost-effective financing and reimbursement policies to accomplish program objectives, including prepayment and selective contracting with efficient providers. States must be able to exclusively rely on such financing arrangements. States could not realistically implement such approaches in a temporary program if they are required to provide eligible individuals with traditional fee-for service options as in H.R. 3021. In the context of a temporary program that serves a unique population, providers simply would not be willing to risk the potential costs of adverse selection that could easily result from such an approach. Many unemployed workers had employer paid private insurance that required a "deductible" out-of-pocket payment before insurance coverage began. The consequences of H.R. 3021's first dollar coverage coincident with the idle time of newly unemployed individuals is unknown.

An Alternative Approach

While we believe that the best approach would be a program that gives states total flexibility in the design of eligibility, benefits, financing, and administration of the program, we recognize that Congress has legitimate concerns in this regard, including:

- If states have total latitude with respect to means testing some states could require unemployed individuals to impoverish themselves (by depleting all financial resources) before becoming eligible for the program.
- With no specification of which services would be covered, the federal government would have little assurance that federal funds were being expended for the intended purpose.
- Very large beneficiary contribution requirements could make the program and/or needed services unaffordable for unemployed individuals.

To address these Congressional concerns, we would propose the following alternative approach:

The suggested program structure would authorize grants to states rather than establish personal entitlement program, and would meet the following specifications:

Eligibility

Give states the latitude to consider income and resources, but provide that resources such as homes and automobiles, and income needed to meet loan payments on such items, be disregarded from gross resources and income. (The population states could cover would be constrained to current and previous Unemployment Insurance beneficiaries.)

Services Covered

Require coverage of certain services (inpatient hospital, emergency outpatient, physician services, prenatal and post-partum care) but allow state determination of amount, duration and scope and any exceptions to such limits for reasons of medical necessity.

Premiums/Cost Sharing

Set upper limits on the percent of unemployment compensation benefit that would be charged as a premium and upper limits on the estimated average client cost of copayments and deductibles. Within these aggregate limits, allow states to structure such requirements any way they choose. (If a state opts to use private insurance rather than Medicaid, beneficiary cost sharing requirements could be higher so long as they do not exceed levels typical of private insurance plans offered to employed individuals in that state. Further, discounted private insurance programs for the unemployed such as Pennsylvania's would be "grandfathered.") States would be allowed to use resulting revenues and/or expenditure reductions to meet any non-federal share of program benefit costs.

Program Administration

Allow states to use appropriate state, local and private agencies to determine eligibility and to administer claim payment functions.

Reimbursement and Financing Policies

Allow states to use whatever cost-effective and expeditious reimbursement policies they choose to accomplish program objectives, including exclusive contracting with specified providers and capitation based reimbursement. States should be able to use alternative financing arrangements, including delegating funding and responsibility to health care provider consortia in a given area, or subsidizing the purchase of traditional private insurance where discount rates for the unemployed have already been arranged by the state.

State Matching Requirements

NGA would continue to oppose requirements for the expenditure of state funds. If the Congress insists on matching funds, NGA would urge a compromise approach wherein the levels are low enough that states could meet such requirements through beneficiary premium revenues and program savings accruing from beneficiary cost-sharing requirements, rather than state funds.

Mr. Chairman, we appreciate the opportunity to share our views and we would be happy to answer any questions.

Mr. **Ford**. Thank you. Mr. Curtis.

Mr. **Curtis**. I am here with Mr. Scheppach to answer any questions.

Mr. **Ford**. Mrs. Klinger, supervisor, Merced County, Calif.

STATEMENT OF ANN KLINGER, SUPERVISOR, MERCED COUNTY, CALIF., ON BEHALF OF THE NATIONAL ASSOCIATION OF COUNTIES

Ms. **Klinger**. Thank you, Mr. Chairman.

I am Ann Klinger, a member of the Merced County, Calif., Board of Supervisors and of the board of directors of the National Association of Counties.

NACo appreciates the opportunity to appear before you today to comment on pending legislation to provide health care for the unemployed and direct assistance to public hospitals. We commend this committee's efforts to work out a solution to this critical problem.

As providers, financers, planners, and purchasers of health care services, counties in one way or another have a role in addressing the health care needs of virtually all Americans. Of the 1,900 public hospitals in this country, over 900 are county facilities serving as providers of last resort to the indigent and the "new poor" among the unemployed who have lost their health benefits but do not qualify for medicaid or other forms of assistance. The number of people in this situation has greatly increased, and it is now estimated that more than 21 million workers and family members will be without health insurance coverage sometime during this year.

While many are turning to county government and voluntary health care programs, others are deferring health services in hopes that they will soon be able to return to work and health insurance coverage. This postponement of needed health care can unfortunately lead to graver illnesses and more costly hospitalization down the road.

Nationwide, local tax revenues support the provision of county health services for many of these millions of Americans who have no health coverage. In 1980, counties spent over $22 billion on health care, which accounted for 36 percent of all county expenditures nationwide. The largest public hospitals provided close to $1 billion in non-medicaid charity care in 1980—about 25 percent of these public hospitals are county-owned.

NACo has seen an increase in the county public hospitals who are struggling to keep their doors open—county hospitals in Wayne County, Mich.; Mobile County, Ala.; St. Louis County, Mo.; Chatham County, Ga.; Jefferson County, Ala.; and others.

Kern County, Calif. has seen a dramatic decrease in the number of medical and indigent patients (those with no health insurance) that private physicians and hospitals will take. Therefore, the number of emergency room visits in the county-owned hospitals are increasing; and the county has seen an 8-percent overall increase in admissions, with a 20-percent increase in the month of May.

They are also alarmed about the number of patients deferring health care. They are seeing them when they are sicker and, therefore, more costly to treat. Our economy is agricultural, characterized by a large number of migrant workers. The unemployment rate in my county is 20.3 percent.

Further, we are facing an economic slump in agriculture intensified by the California cooperative of growers. Additionally, the PIK program will affect the number of jobs in the area. Reduced acres planted will mean fewer workers required to both plant and harvest crop.

Each agriculture job deleted has a ripple effect on every other business and industry in our country. Our county has been declared a flood disaster area. The farmers simply couldn't get in the field to plant crops this year. That caused increased unemployment.

This year our county has a $10 million shortfall in our general fund. Our general relief costs which are 100 percent county dollars doubled this year, and they are projected to double again next year. We had a 148-percent increase in prior years. This parallels a cutback in the CETA dollars from $10 million in 1978-80 to $2.6 million in 1982-83 with a further large cut expected next year.

The agricultural nature of our county has attracted an influx of refugees from the mountains of Laos and an unplanned secondary migration. Ninety to 95 percent of these individuals are unemployed. Thirteen percent of the population of the city of Merced and 5 percent of our county's population are now Southeast Asian refugees. At our county hospital, almost 14 percent of the patients and 14 percent of the pediatric patients are from this population group. This is in addition to serving the other unemployed in our county and absorbing the bad debts and indigent care costs.

A neighboring county to the north also has a county hospital. Their unemployment rate is even higher than our 20.3 percent. Whether you are talking about Lake County, Ind., where they are seeing major increases in the number of medically indigent or the State of Michigan where they are also seeing unprecedented numbers of unemployed people who are medically indigent, or Hennepin County, Minn., that did a survey and found that 30 percent were deferring medical care, it is apparent that there is an urgent need for the legislation under consideration by your committee.

In Mobile County, Ala., officials stated that their hospital has been forced to spend $20 million in indigent care in 1982. Harris County, Tex., had a 12-percent increase in indigent outpatient care in 1982. Officials say two-thirds of this increase is due directly to unemployment. Last year over two-thirds of the county hospital's $150 million budget went to provide charity care.

Other examples are also in the written testimony which will be in the record.

NACo is concerned that in H.R. 3021 States having average unemployment rates below 133 percent of the national average unemployment rate will not participate, due to the match requirement. Counties with average unemployment rates above the State average would have no alternative.

S. 3021 addresses this issue and authorizes a State to receive Federal funds for targeted high unemployment areas, even after a State's average unemployment rate falls below 6 percent. We support the provision, as it recognizes the hidden local high unemployment rates that are not evident in State averages.

However, we feel that the legislation should protect all eligible individuals in all local government jurisdictions, while providing incentives to those States, if their average unemployment rates are below 133 percent of the national average unemployment rates that apply for grants.

Therefore, we recommend that your committees consider the following:

If a State's average unemployment rate is under 10 percent, but it has areas of unemployment exceeding 10 percent the State should receive comparable Federal reimbursement for those areas to offset the total State match.

For all other areas, a State would be required to provide its proportionate share of program costs.

NACo would also like to stress that if final legislation results in block grants to States, the dollars must be targeted to insure adequate service to those areas with the highest number of uninsured persons. A substate allocation formula should reflect similar factors used in allocating the Federal dollars to the States. Money could be distributed to jurisdictions based on the locality's share of the State's average unemployment rate.

The legislation makes basic health benefits available to unemployed workers and their dependents who have no private health insurance coverage and who are not eligible for medicaid. The statistics and concerns that we have described point to the need for this legislation.

NACo supports the use of the U.I. and medicaid programs because it makes sense to use systems already in place. We also support the suspension of the State matching requirement which exists in the present medicaid program. Especially since some 14 States presently require a local match.

County governments cannot afford to provide the total non-Federal match for a program, given their financial burdens which we have described here today. The report language for H.R. 3021 allows a State total discretion as to whether the local jurisdiction should pay the State share of the program costs. Such financial mandates should not take place without the consent of the local jurisdiction, and we hope that final legislation will reflect that a county may choose whether or not to implement a program based on whether or not a match is required.

Administrative moneys must be passed through and counties need to be assured that this money will, in fact, flow to the local level and in a timely fashion. The claims processing is an expensive administrative duty that we would be involved in, as many medicaid agencies are county-based.

There are also proposals to create a new part B of title XX, a block grant to States to provide health insurance for the unemployed. Our major concern is that specific provisions be included to protect existing title XX programs and to prohibit program transfers between the already limited social services and the health insurance program.

Once again, administrative costs must be passed through to counties responsible for carrying out the program. Too often, we get the charge, and not the dollars to go with it.

We support the considerable flexibility in S. 3021. States have the choice, and hopefully will be encouraged to consult with counties, as major providers, of administering benefits through a public program or using the unemployment compensation offices and the medicaid agencies or through a State insurance pool.

We would encourage alternatives to the traditional medicaid fee-for-service schedules, that offer unemployed workers a choice of plans, pre-paid or otherwise. Many counties are successfully serving as the administrators and brokers under medicaid's freedom of choice waivers. In some cases these approaches may not be feasible for States who do not have resources to carry them out. Furthermore, many States may need to get the dollars quickly to the unemployed. But it is necessary to allow room for creativity and variations in models for the provision of indigent care.

The struggling public hospitals are of great concern to us. They are providers of last resort for the vulnerable populations: The elderly, poor women and children, the disabled, and the millions of unemployed. Today we have outlined the problems that counties and their public hospitals face. These institutions really must be helped so that they can continue to serve as the health care providers to many who otherwise would do without.

We would like to thank you once again for the opportunity to comment. NACo will be happy to work with you and your staff to provide continued assistance in the development of sound programs to provide relief to the millions without means to purchase health care and to the public institutions serving as a last resort. We will also be pleased to continue to provide information on both programs regarding their implementation at the county level where the health services are provided.

At this point, I will be glad to answer any questions you may have.

[The prepared statement follows:]

STATEMENT OF ANN KLINGER, SUPERVISOR, MERCED COUNTY, CALIF., ON BEHALF OF THE NATIONAL ASSOCIATION OF COUNTIES [1]

I am Ann Klinger, a member of the Merced County, California Board of Supervisors and of the board of directors of the National Association of Counties.

NACo appreciates the opportunity to appear before you today to comment on pending legislation to provide health care for the unemployed and direct assistance to public hospitals. We commend this committee's efforts to work out a solution to this critical problem.

As providers, financers, planners and purchasers of health care services, counties in one way or another have a role in addressing the health care needs of virtually all Americans. Of the 1900 public hospitals in this country, over 900 are county facilities serving as providers of last resort to the indigent and the "new poor" among the unemployed who have lost their health benefits, but do not qualify for medicaid or other forms of assistance. The number of people in this situation has greatly increased and it is now estimated that more than 21 million workers and family members will be without health insurance coverage sometime during this year.

While many are turning to county government and voluntary health care programs, others are deferring health services in hopes that they will soon be able to

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[1] The National Association of Counties is the only national organization representing county government in the United States. Through its membership, urban, suburban, and rural counties join together to build effective, responsive county government. The goals of the organization are to: improve county government; serve as the national spokesman for county government; act as a liaison between the nation's counties and other levels of government; achieve public understanding of the role of counties in the Federal system.

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return to work and health insurance coverage. This postponement of needed health care can unfortunately lead to graver illnesses and more costly hospitalization down the road.

COUNTY ROLE

Nationwide, local tax revenues support the provision of county health services for many of these millions of Americans who have no health coverage. In 1980, counties spent over $22 billion on health care, which accounted for 36 percent of all county expenditures nation-wide. The largest public hospitals provided close to a billion dollars in nonmedicaid charity care in 1980—about 25 percent of these public hospitals are county-owned.

NACo has seen an increase in the county public hospitals who are struggling to keep their doors open—county hospitals in Wayne County, Michigan; Mobile County, Alabama; St. Louis County, Missouri; Chatham County, Georgia; Jefferson County, Alabama; and others.

Kern County, California has seen a decrease in the number of medical and indigent patients (those with no health insurance) that private physicians and hospitals will take. Therefore, the number of emergency room visits in the county-owned hospital are increasing; and the county has seen an 8 percent overall increase in admissions, with a 20 percent increase in the month of May. The county is also alarmed at the number of patients who seem to be deferring health care. They are sicker when they come in, and subsequently costs are greater for all.

Lake County, Indiana is seeing an increase in the number of people with no health coverage. Many have drained their assets and are now eligible for medicaid and other public assistance. To pay for this the county has issued a $5 million bond for its public welfare department.

In the State of Michigan, counties are seeing an unprecedented number of unemployed people who are medically indigent because they have lost health insurance, but do not qualify for public assistance. Counties are also seeing long-term unemployed who now qualify for general assistance and medicaid benefits because they have exhausted their assets.

Hennepin County, Minnesota has determined that the "Medically Indigent" population—those who don't qualify for medicaid but have no health insurance—has increased and is climbing. These people receive a substantial portion of their medical care through county and State dollars. The county recently completed a survey of the effect of Federal/State cuts where poeple have lost their comprehensive health coverage. Thirty percent of the respondents stated that they were deferring all medical care.

In Mobile County, Alabama, the university's general hospital has finally agreed to re-open its emergency room doors because the county guaranteed to supplement the $2.3 million it already pays to the hospital for indigent care under contract. Officials state that the 16.1 percent unemployment rate has forced the hospital to spend $20 million in indigent care during 1982. Increasingly, this hospital is seeing non-insured patients referred by other hospitals or doctors.

In Texas where unemployment is 10.5 percent, Harris County has seen a 12-percent increase in indigent outpatient care in 1982. County officials state that at least two-thirds of this increase is due directly to unemployment. Last year over two-thirds of the county hospital's $150 million budget went to provide charity care. Harris County has been considering development of a prepaid health plan for this group of uncovered people but has been unable to start it due to lack of resources and money.

New York State has been forced to close or substantially decrease many services provided at in-patient mental health facilities.

Chautauqua County has noted that, at the same time that the stress of unemployment has led to a rise in the requests for mental health services, the county and other mental health service providers are suddenly being inundated with former inpatients of State facilities. As a result, many persons desperately in need are not receiving services.

A. State matching

NACo is concerned that States having average unemployment rates below 133 percent of the national average unemployment rate will not participate, due to the match requirement. Counties with average unemployment rates above the State average would have no alternative. S. 3021 addresses this issue and authorizes a State to receive Federal funds for targeted high unemployment areas, even after a State's average unemployment rate falls below 6 percent. We support the provision, as it recognizes the hidden local high unemployment rates that are not evident in State averages.

However, we feel that the legislation should protect all elgible individuals in all local government jurisdictions, while providing incentives to those States, if their average unemployment rates are below 133 percent of the national average unemployment rates that apply for grants.

Therefore, we recommend that your committees consider the following:

If a State's average unemployment rate is under 10 percent, but it has areas of unemployment exceeding 10 percent or above those local jurisdictions' share of program costs would be 100 percent federally matched and waived from the amount required to be matched by the State.

For all other areas, a State would be required to provide its proportionate share of program costs.

States could not receive Federal grant funds for any substate jurisdiction unless it complies with the match requirement for those areas having average unemployment rates under 10 percent.

B. Targeting

NACo would also like to stress that if final legislation results in block grants to States, the dollars must be targeted to ensure adequate service to those areas with the highest number of uninsured persons. A substate allocation formula should reflect similar factors used in allocating the Federal dollars to the States. Money could be distributed to jurisdictions based on the localities' share of the State's average unemployment rate.

C. Administration

The legislation makes basic health benefits available to unemployed workers and their dependents who have no private health insurance coverage and who are not eligible for medicaid. The statistics and concerns that we have described point to the need for this legislation.

NACo supports the use of the U.I. and medicaid programs because it makes sense to use systems already in place. We also support the suspension of the State matching requirement which exists in the present medicaid program. Especially since some 14 States presently require a local match.

County governments cannot afford to provide the total non-Federal match for a program, given their financial burdens which we have described here today. The report language for H.R. 3021 allows a State total discretion as to whether the local jurisdiction should pay the "State" share of the program costs. Such financial mandates should not take place without the consent of the local jurisdiction, and we hope that final legislation will reflect that a county may choose whether or not to implement a program, based on whether or not a match is required.

Administrative monies must be passed through and counties need to be assured that this money will, in fact, to the local level and in a timely fashion. The claims processing is an expensive administrative duty that we would be involved in, as most medicaid agencies are county-based.

There are also proposals to create a new part B of title XX, a block grant to States to provide health insurance for the unemployed. Our major concern is that specific provisions be included to protect existing title XX programs and to prohibit program transfers between the already limited social services and the health insurance program. Once again, administrative costs must be passed through to counties responsible for carrying out the program.

We support the considerable flexibility in S. 3021. States have the choice, and hopefully, will be encouraged to consult with counties, as major providers, of administering benefits through a public program, or using the unemployment compensation offices and the medicaid agencies, or through a State insurance pool. We would encourage alternatives to the traditional medicaid fee-for-service schedules, that offer unemployed workers a choice of plans, pre-paid or otherwise. Many counties are successfully serving as the administrators and brokers under medicaid's freedom of choice waivers. These approaches may not be feasible for States who do not have resources to carry them out. Furthermore, many States may need to get the dollars quickly to the unemployed. But it is necessary to allow room for creativity and variations in models for the provision of indigent care.

D. Assistance to public hospitals

The struggling public hospitals are of great concern to us. They are providers of last resort for the vulnerable populations: The elderly, poor women and children, the disabled—and the millions of unemployed. Today, we have outlined the problems that counties and their public hospitals face. These institutions must be helped so that they can continue to serve as the health care providers to many, who otherwise, would do without.

Therefore, we support direct grants to public hospitals in order to assist them in providing services to low-income individuals without public or private insurance coverage.

We would like to thank you once again for the opportunity to comment. NACo will be happy to work with you and your staff to provide continued assistance in the development of sound programs to provide relief to the millions without means to purchase health care and to the public institutions serving as a last resort. We will also be pleased to continue to provide information on both programs, as to its implementation at the county level where the health services are provided.

At this point, I will be glad to answer any questions you may have.

Chairman **Ford**. Thank you very much.

Listening to your testimony there, I get the feeling you are not totally opposed to the block grant, but at the same time, there are certain stipulations that must go with that if that legislation is reported as in the bill before the committee now, is that correct?

Ms. **Klinger**. That is correct, Mr. Chairman.

We really feel the targeting and other provisions I mentioned must be in a block grant. We wouldn't totally oppose a block grant.

Chairman **Ford**. We have heard earlier Mr. Gradison and Mr. Pease and some of the others who have talked about providing the protection for any family with children below the poverty level regardless of the employment status. What would happen if we would require the States to provide the health care insurance not only for the unemployed but those below the poverty level? What would be the position of the States if we were to include that provision in one of the plans?

I think it is already within the plan being presented by Mr. Rangel with the optional block granting.

Mr. **Scheppach**. Mr. Chairman, we would have great problems with that provision. No. 1, it would be a Federally mandated entitlement program. States have great problems with that given the unpredictability of program costs. Given that 49 States have constitutional or statutory requirements that they can't deficit finance, if the costs of such a program increase, States would have to go back and raise taxes or cut other programs.

Second of all, it is a universe that we don't have much experience with, we don't know how large it is or how fast it is going to grow.

Another even more significant point is that a disproportionate number of the population to be entitled probably lies more in rural States. And Federal funds would be allocated on a very different formula. So you might in fact get a mismatch between demand in States, particularly in rural poor States, and the allocation of Federal moneys, which are allocated according to the general unemployed population.

Chairman **Ford**. Thank you very much.

Mr. Pease.

Mr. **Pease**. Mr. Chairman, I don't think I have any questions. Thank you.

Chairman **Ford**. Mr. Moore.

Mr. **Moore**. One brief question, Mr. Chairman.

Mr. Scheppach, in the bill that comes to us from the Commerce Committee, as I understand it, an amendment was added at the last minute that will allow a State that has targeted areas of unemployment above 6 percent to receive the Federal matching funds.

The original language of the bill didn't do that. If you were below the line you got nothing; if you were above, you got something. Wouldn't this cause an unworkable approach for Governors and for statewide agencies to have a situation where one part of the State is entitled to this unemployment compensation health insurance, while another part of the State is not? Wouldn't you have an unemployed worker in one part of the State being denied and an unemployed worker in another part of the State getting the coverage?

Do you think this would cause a problem to the Governors you represent?

Mr. SCHEPPACH. I think it would, Mr. Chairman.

Mr. MOORE. Thank you. No further questions.

Chairman FORD. Mr. Gephardt.

Mr. GEPHARDT. No questions.

Chairman FORD. The committee would like to thank the panel for testifying today. Thank you very much for your appearance.

Mr. SCHEPPACH. Thank you, Mr. Chairman.

Ms. KLINGER. Thank you, Mr. Chairman.

Chairman FORD. The Chair will call the Interstate Conference of Employment Security Agencies, Mr. Cecil J. Blache, administrator, Louisiana Office of Employment Security.

Mr. Moore, at this time we would be happy to recognize you for introduction of the next witness.

Mr. MOORE. Thank you very much, Mr. Chairman.

The gentleman, of course, is the head of our Employment Security Agency in Louisiana, and is also a member of the board of the national organization.

Our State has just gone through a very traumatic situation. We have had to reduce benefits and increase taxes to keep the unemployment compensation program on an even keel. So I think his testimony ought to be particularly helpful to us in terms of how the State administrators are going to have to run this program. I think that is why he is here: to give us technical information in that regard.

Chairman FORD. Mr. Blache, you are recognized at this time.

STATEMENT OF CECIL J. BLACHE, ADMINISTRATOR OF LOUISIANA OFFICE OF EMPLOYMENT SECURITY ON BEHALF OF INTERSTATE CONFERENCE OF EMPLOYMENT SECURITY AGENCIES, INC. ACCOMPANIED BY CHERYL TEMPLEMAN, STAFF EMPLOYEE FOR INSURANCE

Mr. BLACHE. Thank you.

My name is Cecil J. Blache. I am administrator of the Louisiana Office of Employment Security and a member of the board of directors of the Interstate Conference of Employment Security Agencies, Inc. ICESA is the organization that represents State administrators of unemployment compensation laws and public employment offices throughout the country. My comments today are made from ICESA's viewpoint as administrators of the unemployment insurance, UI, program, and are limited to the role assigned to the UI system by H.R. 3021.

I would like to introduce Cheryl Templeman, ICESA staff member for unemployment insurance, who is accompanying me today.

I have a prepared statement and request that it be made a part of the record.

Chairman **Ford**. So ordered.

Mr. **Blache**. Thank you.

Section 2102(a)(3) charges the State UI systems with substantial administrative responsibilities. As you know, UI benefits are paid under State laws. There are significant variations in the laws and procedures among the various States. Because of this, we anticipate some problem areas arising in the way the bill is structured at this time.

We feel that there will be some difficulty in administration of some aspects of this bill. I would like to point out a few of them.

Interstate unemployment claims is a problem area. The bill now provides merely that the health plan shall cover persons eligible for unemployment insurance in the State The interstate claimant is one who files his claim in the State of residence as opposed to where he worked. However, the State where he worked is responsible for paying benefits to the individual.

The problem here is that, of course, a health plan should be available where a person is living rather than in the State that pays his benefits. This problem is not addressed in the bill at this time. We are uncertain exactly how we will be able to administer that aspect of it.

A similar problem is commuter claims. The D.C. area is a good example. Many people live in one State, work in another, and are able to file their claims in the State where they worked because of the close proximity of their residence to the State of work. These people should be eligible for health care coverage in the State that pays their benefits rather than the State where they live.

Another problem area for us in the bill is the provision for targeted sub-State areas. Everytime a UI recipient had a change of address we would have to check to see whether he became eligible or lost eligibility for health care coverage by moving into or out of the target area.

There are a few other technical problems. Right now the bill states that 3 weeks after receiving the first week of benefits, an individual would be eligible to come under a health plan. It is not clear whether this means calendar weeks or weeks of benefits. There are often interruptions in the claim and occasional delays due to the time it takes to process a claim.

We just need additional clarification about when a person would be eligible for health care coverage. We ask that additional language be included to describe exactly what the bill intends.

Another section we are concerned about is the definition of "employed." States have different definitions of when an individual is employed or unemployed. We are asking that you permit each State to use the same definition of "employed" for health care coverage as it does for UI purposes.

Right now, the law states that those who are unemployed are those individuals who do not earn in excess of three times the Federal minimum wage. In some States, the weekly benefit exceeds three times the Federal minimum wage. In Louisiana, for instance, an individual can receive as much as $205 a week in benefits; he would be eligible for benefits but not eligible for the health plan because you can't give it to anyone earning in excess of $117.

Another area we are concerned about is the premium. It is 2 to 5 percent of the weekly benefit amount. Is this meant to vary on a weekly basis or be set at a fixed amount at the time of the initial application?

An individual's weekly benefit amount may vary due to outside earnings which decrease the amount of benefits received from the unemployment insurance system.

One last area I would like to address is the requirement that health care coverage terminated 4 weeks after the individual returns to work. We monitor people who are unemployed and requesting benefits. Once they leave our rolls—I should say once they stop coming into our office—it doesn't necessarily mean that they have, in fact, returned to work. In some instances, they may have just dropped out of the labor market.

We don't have information regarding whether these persons have, in fact, returned to work or when they returned to work. We hope that some clarification could be given in that area.

In conclusion, we appreciate the opportunity to come before you and point out the technical problems we have with this bill. Whatever is passed by Congress, we will be more than happy to try to implement.

Again, the system has been operating, as you know, in the present recession, under serious strain. We have experienced the highest claim loads ever. We have new programs, three Federal extensions, and we face many problems already.

We hope you take into consideration the fact that the administrative problems we will face will be significant if, in fact, the legislation is passed without some clarifications and technical improvements.

Thank you.

Mr. FORD. Thank you.

[The prepared statement follows:]

STATEMENT OF CECIL J. BLACHE, ADMINISTRATOR, OFFICE OF EMPLOYMENT SECURITY, BATON ROUGE, LA., REPRESENTING INTERSTATE CONFERENCE OF EMPLOYMENT SECURITY AGENCIES, INC.

My name is Cecil J. Blache. I am Administrator of the Louisiana Office of Employment Security and a member of the Board of Directors of the Interstate Conference of Employment Security Agencies, Inc. (ICESA). ICESA is the organization that represents state administrators of unemployment compensation laws and public employment offices throughout the country. My comments today are made from ICESA's viewpoint as administrators of the unemployment insurance (UI) program and are limited to the role assigned to the UI system by H.R. 3021.

The "Health Care for the Unemployed Act" would provide medical assistance to unemployed workers who are receiving UI benefits and those that have been eligible for benefits within the past two years. The unemployment insurance system would have substantial administrative responsibilities under H.R. 3012. Specifically, a state plan for medical assistance would make the unemployment insurance system responsible for the following tasks:

Informing each individual who is eligible for unemployment compensation in the state about the terms and conditions of enrollment in the health care plan;

Providing to the entity administering the plan, on a weekly basis, the names of individuals who are receiving benefits and those disqualified due to fraud;

Requiring that those who enroll in the plan provide information about any other health coverage for which they might be eligible. This information would be provided weekly to the entity administering the plan;

Providing names and addresses of those who exhausted in the last two years; and cooperating with the entity administering the plan in verifying eligibility and ascertaining grounds for ineligibility.

As you know, unemployment benefits are paid under state laws. There is substantial variation among the states in law and procedures. In order to make administration of the health care plan as simple as possible, we urge you to allow states flexibility whenever possible. The following comments identify some aspects of H.R. 3021 that would be difficult for the unemployment insurance system to administer, some issues that need to be clarified and some suggestions for improvement.

INTERSTATE UNEMPLOYMENT CLAIMS

One of the most aspects of administration will be the treatment of individuals who are claiming unemployment benefits on an interstate basis. They live in one state but receive benefits from another. Unemployed workers file UI claims against the state where they worked, regardless of where they live. About 250,000 individuals are currently claiming benefits on an interstate basis; about 5.3% of UI recipients nationwide. Interstate claims are not specifically addressed in the bill. The state UI agency is required to "assure that each individual who becomes eligible for employment compensation in the State is informed . . ." This could be interpreted to mean either residing in the state or eligible under the state unemployment compensation law. The former would include those who live in the state and receive benefits from another state. The latter would include those receiving UI benefits from the state but living elswhere. The only practical way to go for interstate claimants is by state of residence, for the obvious reason that health care must be obtained locally. However, after an initial visit to the local office, the interstate claimant generally deals directly with the state that pays his benefits. The UI agency in the state where he lives has no information about whether he is receiving benefits or not and therefore could not furnish this information to the entity administering the plan. If the interstate claimant chose to enroll in the plan, his claim status could perhaps be verified periodically by the state paying his benefits. Premiums would have to be paid directly by the claimant rather than collected by deductions from the weekly benefit amount.

A similar problem is commuter claims. In labor markets like the D.C. metropolitan area, people often live in one state and work in another. They file their claims (on an intrastate basis) where they worked because they live close enough to do so. It would be simpler if these individuals were eligible for health care coverage in the state where they are filing their claims rather than were they live because that agency has the information needed to verify eligibility for coverage.

TARGETING ASSISTANCE WITHIN A STATE

Targeting health care to substate areas would create additional administrative problems since, in many cases, both those claimants who live in the targeted area and those who do not would be reporting to the same local offices to file their unemployment insurance claims. Those potentially eligible would have to be identified and informed, rather than informing everyone. UI recipients might move in or out of a target area during the course of their claims, making it necessary to check every time any claimant changed his address in order to determine whether he had become potentialy eligible for health care coverage based on the new address.

VERIFYING ELIGIBILITY AND GROUNDS FOR INELIGIBILITY

In addition to the responsibilities outlined for the unemployment insurance system directly, the UI agency would likely be the source of other information needed for determining eligibility. Some of these eligibility criteria need to be clarified.

Individuals receiving UI may be eligible for coverage after four weeks (Sec. 2102(c)(1)(A)). This could be interpreted as either the first three calendar weeks after the first week for which the individual received benefits or the fourth week for which benefits are paid. There are often interruptions in the claim sequence due to temporary employment, illness, failure to search for work, etc. Normally, states do not keep track of which week of the claimant's benefit year is being claimed. They do keep a running tally of the number of payments. Therefore, setting eligibility at the fourth compensable week (or fourth consecutive compensable week) would be easier to deal with administratively. The term "compensable week" would include weeks for which the claimant was eligible but benefits were not paid due to some delay in the claim processing.

Section 2102 (c)(4) requires a state standard for defining when an individual is considered employed. That standard cannot exceed weekly earnings of 30 times the minimum hourly wage, i.e., $117. For unemployment insurance purposes, the definition of when an individual is employed usually relates to the weekly benefit amount. Typically, if his earnings during a week are greater than his weekly benefit amount (wba) or the wba plus a certain amount, the individual is considered employed. Under this provision, there will be cases where individuals will be considered employed under the health care plan but still receiving UI benefits (when the wba exceeds $117). We urge you to allow each state plan to use the same definitions of "employed" and "unemployed" as are used for state unemployment compensation purposes.

Individuals are ineligible for coverage after they have been employed for four consecutive weeks. The State unemployment compensation agency will not necessarily be able to provide information regarding return to work. Often people simply stop claiming benefits. They may have returned to work or dropped out of the labor force.

The state is required to charge a premium of between 2 percent and 5 percent of the "amount of the unemployment compensation, if any, which the enrollee receives for the week". Several questions arise in connection with this provision. Does the compensation include dependents allowances? Is the premium meant to be reduced when the benefit check is reduced ~~due to ear~~nings? If the calculation of the premium must be made each week rather than a set amount being calculated at the time the individual enrolls, administration will be more complicated and costly.

We appreciate the opportunity to make these technical comments regarding H.R. 3021. In closing, there is just one additional point we would like to bring to your attention. The unemployment insurance system is strong and resilient, but there are limits to its ability to take on additional responsibilities. During this recession, it has absorbed the shocks of an enormous increase in claims and three federal extensions of benefits. Child support intercept and changes to the eligibility requirements for former military personnel have been implemented. Due to financial constraints, our data processing capability lags behind the available technology. Implementing health coverage will be a very tough job for most states; some estimate that six months will be needed. In spite of these difficulties, we stand ready to do our best to implement whatever plan for health care that Congress agrees upon and state authorities choose to participate in. We do ask, however, that you consider the strain that the system is under and the administrative impact of the provisions you adopt.

Chairman **Ford**. Mr. Moore?

Mr. **Moore**. Thank you, Mr. Chairman.

Mr. Blache, I really appreciate your coming to testify. I think that you have given us very helpful testimony on the very practical problems we are about to create with a new program.

Let me ask you: Due to the fact that if we do an entitlement program, which is the way the bill comes to the committee, the program then has to address all these problems, many of which we don't even see now. Certainly, you are the expert in administering it. You may not even see them now. An entitlement is one approach.

Would it not be a better approach to give you a block grant and let you run the program, devise and take care of the program yourself, so we at the Federal level avoid trying to foresee and handle the problems you are bringing to us this morning?

Mr. **Blache**. Representative Moore, more than anything else our concern is that, in fact, any new program is an additional burden on the system. Using our State as an example, two-thirds of the staff we have working in employment security are temporary in nature, far beyond our base staff.

What I am saying, in a nutshell, is that the administration of any new plan would be an additional burden on the system at this time. I would look upon the fact of a block grant more as a determination of policy as opposed to technical application. Personally, I would hate to see us have an additional extensive program, which is what it sounds like under a block grant system for our system to operate.

Mr. MOORE. That is because you just don't feel you have the personnel to handle the program, in any event?

Mr. BLACHE. That is correct.

Mr. MOORE. Thank you.

Chairman FORD. Mr. Pease.

Mr. PEASE. No questions.

Chairman FORD. Mr. Gephardt.

Mr. GEPHARDT. No questions.

Chairman FORD. Mr. Shannon.

Mr. SHANNON. No questions.

Chairman FORD. Mr. Blache, thank you very much for your testimony.

Mr. BLACHE. Thank you.

Chairman FORD. The committee will recognize the National Association of Public Hospitals, Mr. Philip Sowa, executive vice president and director of the Regional Medical Center in Memphis, Tenn., formerly known as the City of Memphis Hospital.

With him is Mr. Larry Gage, president and general counsel of the National Association of Public Hospitals; and American Hospital Association, Mr. Jack W. Owen, executive vice president; American Medical Association, Dr. Jerald R. Schenken, member of the council on legislation.

I might say, as the Congressperson from the Memphis area, and I represent the area in which the medical center is located, I would like to take this opportunity to welcome you before the joint committees today and we look forward to your testimony.

We know the City of Memphis Hospital, the older former City of Memphis Hospital has been one located right in the urban distress area. We know about the new facilities that you have underway now.

I have talked to the county manager and he has expressed his concerns. I know there is a grant application for funds in now. I would hope that would be signed off on in the near future. I would hope this legislation would in fact give the type of relief needed for public hospitals.

At this time, the Chair would recognize you.

STATEMENT OF PHILIP SOWA, EXECUTIVE VICE PRESIDENT AND DIRECTOR, REGIONAL MEDICAL CENTER, MEMPHIS, TENN., ACCOMPANIED BY LARRY S. GAGE, PRESIDENT, NATIONAL ASSOCIATION OF PUBLIC HOSPITALS

Mr. SOWA. Thank you, Mr. Chairman and members of the subcommittee.

I am Philip Sowa, executive vice president and director of the Regional Medical Center at Memphis. I am accompanied this morning by Larry Gage.

On behalf of the Regional Medical Center at Memphis, and the 42 other public hospitals and hospital systems around the country which now comprise the membership of our association, I appreciate this opportunity to testify today on the subject of the serious health needs of unemployed Americans who are without health insurance.

NAPH member hospitals serve as the health safety net for all uninsured persons in many of our Nation's metropolitan areas today. On several occasions, we have singly or collectively urged your serious attention to this problem in the last year and we are thus pleased to have this opportunity to work with you on some possible solutions.

In my testimony this morning, I would like to cover three major areas.

First, I would like to briefly describe the situation of public hospitals today, and reemphasize for the committee the important and unique role of public hospitals, with particular attention to the services they continue to make available to all uninsured persons, regardless of their severity of illness or ability to pay.

Second, I would like to share with the committee a specific overview of our situation in Memphis, by way of illustrating some of the significant problems being encountered by hospitals serving uninsured persons in areas of high unemployment.

Third, I would like to express strong support for H.R. 3021, and particularly part C of that bill, which establishes a direct grant program for public hospitals and other hospitals serving the poor.

We offer some additional comments on other proposals before the committee. In the interest of time, I will briefly summarize each of these parts of my prepared statement and submit a full statement for the record.

Chairman FORD. Without objection, it will be made a part of the record, Mr. Sowa.

Mr. SOWA. Several national association witnesses have described our Nation's health safety net in some detail in previous testimony before your committee. However, I believe it is appropriate in the context of this hearing to summarize the key elements of America's public health hospital system.

We continue to take all patients, regardless of ability to pay.

We are not part of the hospital cost inflation problem, with costs increasing 5 full percentage points less than the national average.

We receive over 30 percent of our support, on average, from local tax revenues.

We have managed our resources efficiently, with higher occupancy rates and reduced lengths of stay in recent years.

Our uninsured indigent case load—outpatient and inpatient—is at an alltime high, and continuing to rise due to medicaid reductions, patient dumping by private hospitals, and the economic recession.

Just 18 NAPH members provided $193.3 million in outpatient care in 1982, and 20 of our members provided $379 million in inpatient care last year, for uninsured indigents.

Meanwhile, however, we continue to provide high quality health care, specialized services and medical education to benefit all residents of our communities.

I would like to bring you up to date on the situation as it exists today in Memphis, and more specifically at the Regional Medical Center of Memphis.

Regional Medical Center of Memphis is not just a charity hospital. It is a community resource. Our special units are regarded as centers of excellence in such areas as trauma, obstetrics/gynecology, newborn care.

Not only do we provide the finest medical care in these areas, but greatly increase the body of medical knowledge and provide an opportunity for development of higher, more advanced medical skills. Our OB-GYN unit has delivered more babies than all the other hospitals in the area combined. Last year our newborn center admitted 1,300 babies for special care, three to four times the number of admissions by other hospitals on an average. It is highly acclaimed for both the quantity and particularly the quality of care.

The Regional Medical Center of Memphis is a vitally necessary community resource. However, we are caught in an ever-tightening vise.

Like other large public hospitals throughout the country, we are caught between an ever-increasing demand for our services and shrinking resources. It is a vise caused in part by the economic recession and in part by policies formulated at the Federal and State level.

At the national level, there are more than 11 million workers who have lost their jobs, and along with the jobs, their health insurance. In the mid-South, our service areas, more than 38,000 jobs have been lost along with their attendant health insurance benefits.

These new job losers are in addition to the over 162,000 people in our area with incomes at or below the poverty level who consistently have to turn to public care facilities, usually us, when they are in need of medical care.

In our fiscal years 1981 and 1982, we treated 71,000 medically indigent inpatients and outpatients at Regional Medical Center of Memphis. In the current fiscal year, we estimate treating nearly 75,000 patients.

Our cost to provide health care to these medically indigent patients in 1982-83 will be $29,800,000. This represents a 33-percent increase over 1981-82.

Additionally, we are treating more out-of-State indigent patients from Arkansas and Mississippi than ever before; an increase of 21.5 percent for inpatients alone. While these other States do reimburse us for their case, the amount they pay by no means covers the cost of this care.

But this increasing demand for our services is only one jaw of the vise in which we find ourselves. The other jaw is one of shrinking resources. First and foremost of these is medicaid payments.

In the current fiscal year, Tennessee adopted a 14-day inpatient limit on annual medicaid services. This resulted in a $3.5 million cash reduction for our hospital alone. For fiscal year 1984, this loss will increase to $4 million and continue to compound the hospital's cash-flow problem.

The cash problem will be further intensified as a result of private hospitals dumping their medicaid patients on us because of the reductions instituted by the medicaid program.

The Government is not the only factor in our shrinking resources. Another part of this jaw of the vise is the increased competition among private hospitals for paying patients. These patients are either medicare eligible, carry privately purchased or company provided health insurance, or they simply have the resources to pay for their medical needs.

We have seen a continuing media blitz in our area by private hospitals, directed toward attracting more of these paying patients. There are more ads, commercials, and billboards being run by the private hospitals than ever before.

As they attract the paying patients, they continue to transfer the indigent and medicaid patients to the Regional Medical Center of Memphis. Our medically indigent patient load has increased from 35.9 percent in 1982 to 39.3 percent in 1983.

We are indeed caught in a vise between an increased demand for our services and shrinking revenue sources. How are we handling it?

Nationwide, hospital operating costs continue to spiral upward at an average rate of 12 to 14 percent annually. That is for all hospitals, public and private. Public hospitals, however, continue to experience annual cost increases of 9.8 percent per year. Yet, Regional Medical Center of Memphis is projected to experience only a 2.5-percent operating cost increase this year.

While we have held down our operating costs, we have actually increased our services to the community by 4 percent. To increase service and hold down operational costs in the face of increased indigent load and decreased Federal resources has not been easy. We have only been able to do it through increased management efficiency and improved medical care which has resulted in a decrease in the length of stay by patients and an occupancy increase.

It has been more difficult because much of our occupancy increase has come from nonpaying patients. And these medically indigent patients are sicker and often have multiple diagnoses and require more intensive, expensive care, than private patients.

In addition, poor patients also require a wider range of other, nonmedical services such as social workers and specially trained discharge planners which add substantially to the cost of their care.

Despite our clear gains in management efficiency—in large part due to our reorganization of the old City Hospital under a new not-for-profit corporate charter in 1981—we continue to experience serious fiscal problems.

In our first year under this new arrangement, 1981, we were given a county appropriation of $21.2 million. Our objective was simply survival of the hospital, and we needed an additional $11.3 million from the county government to keep the doors open and maintain quality care.

In our second year, we received a slightly higher appropriation, even though it didn't nearly approach the cost increases and patient load we were experiencing. And we still needed help to maintain the quality of care and the access to that care.

Yet the recessionary pressures on the local government which supports us have been especially harsh, with 10.4 percent unemployment in Memphis. And now in our third year of management, we are expected to maintain or increase the quality of care and access to that care with resources that are dwindling, rather than growing. It simply can't be done.

If additional funding is not forthcoming, we do have some alternatives open to us, including new revenue sources to help make up the difference. Yet even these sources—a new trauma center, establishment of new preferred provider arrangements, a new image—are unlikely to provide enough revenue to bridge the budget gap if we are to continue serving all who need care.

Therefore, what is left? More cost cutting. We can close 148 beds. And lay off 400 personnel. That would save $3 million and allow us to operate almost within the projected $27.5 million county budget appropriation.

However, community health services would be reduced to dangerously low levels, and we may not have the capacity to serve all people who need care. We could take a long hard look at the Regional Medical Center of Memphis emergency room, and possibly close it. That would save us $2.5 million to $3.5 million a year, from our projected need of $30 million.

But 73 percent of our gross revenues are directly or indirectly generated via the emergency room. And many of our indigent patients rely on it as well. It would be self-defeating, a denial of the very purpose for the existence of Regional Medical Center of Memphis, to provide the effective medical care to everyone, regardless of their ability to pay.

Today we are caught in the vise of increased demand for our services on one side with shrinking resources on the other. The Regional Medical Center of Memphis is not a charity hospital. It is a community resource.

We didn't create the conditions that are producing the increased need for medical care. We, and our patients, should not be made to bear the sins of the health care system, government policies, and the general state of the economy.

We have reached a point where we may soon no longer be able to afford the quality of care we are now able to provide, particularly for the indigent patient. Congress can clearly help us through the current crisis in Memphis, by enacting legislation before you today, and by increasing your attention to the health needs of all uninsured indigents—not just the unemployed.

With that support, it is by no means as clear that our community resource, the Regional Medical Center of Memphis, can survive.

In the balance of my prepared testimony, I offer a number of comments on the legislation and proposals before you today, including H.R. 3021, which we strongly support, and a new proposal put forth by Representative Rangel this week, which seems to us to be an equally attractive alternative.

Whichever option you choose, the important thing is for this committee to move quickly to make resources available to provide support for health care for this patient population.

I want to thank you again for this opportunity to testify, and I would be delighted to answer any questions you may have.

Chairman FORD. Thank you.

[The prepared statement follows:]

STATEMENT OF PHILIP SOWA, EXECUTIVE VICE PRESIDENT AND DIRECTOR, THE REGIONAL MEDICAL CENTER AT MEMPHIS

Mr. Chairman, members of the Subcommittee, I am Philip Sowa, Executive Vice President and Director of the Regional Medical Center at Memphis. I am accompanied this morning by Larry Gage, President of the National Association of Public Hospitals. On behalf of the Regional Medical Center at Memphis, and the 42 other public hospitals and hospital systems around the country which now comprise the membership of our Association, I appreciate this opportunity to testify today on the subject of the serious health needs of unemployed Americans who are without health insurance. NAPH member hospitals serve as the health safety net for all uninsured persons in many of our nation's metropolitan areas today. On several occasions, we have singly or collectively urged your serious attention to this problem in the last year, and we are thus pleased to have this opportunity to work with you on some possible solutions.

In my testimony this morning, I would like to cover three major areas:

First, I would like briefly to describe the situation of public hospitals today, and to re-emphasize for the Committee the important and unique role of public hospitals, with particular attention to the services they continue to make available to all uninsured persons, regardless of their severity of illness or ability to pay.

Second, I would like to share with the Committee a specific overview of our situation in Memphis, by way of illustrating some of the significant problems being encountered by hospitals serving uninsured persons in areas of high unemployment; and

Third, I would like to express strong support for H.R. 3021, the legislation you have before you today, and particularly Part C of that bill, which establishes a direct grant program for public hospitals and other hospitals serving the poor.

THE SITUATION OF PUBLIC HOSPITALS TODAY

Several NAPH witnesses have described our nation's health safety net in some detail in previous testimony before your Committee. However, I believe it is appropriate in the context of this hearing to call your attention again to several key elements of America's public hospital system—and particularly, those elements which make public hospitals a unique and important asset in any program seeking to provide needed health services to our unemployed citizens:

Public Hospitals Continue to Take All Patients, Regardless of Ability to Pay.—Where public hospitals exist, they are "de facto" national health insurance today. Data collected by the Urban Institute showed that just 15 of the largest public hospitals in the country provided $597 million in non-Medicaid charity care in 1980 alone. "Charity care" comprises over 30 percent of the budget of the average public hospital—as opposed to about 3 percent on average for the private sector.

Public Hospitals Are Not Part of the Hospital Inflation Problem.—NAPH data compiled last year showed an average annual inflation rate for public hospital budgets of just 9.8 percent per year between 1976 and 1980, as opposed to 14.7 percent for the hospital industry as a whole. New data we are compiling this year indicates that this historical gap continues to exist—and indeed in some areas, is widening. In California in 1981, for example, all hospital costs increased 17.9 percent while public hopsital costs increased by just 10.3 percent.

Despite the Persistent Washington, D.C. Myth That Cities and Counties Are Not Paying their Way, a Substantial Portion of the Public Hospital Budget Comes From Local Tax Revenues.—NAPH data shows that 31 percent of our members' budgets come from local appropriations, as opposed to 22 percent from Medicaid and 16 percent from Medicare. Of $2.07 billion in total revenues received by just 23 public hospitals in 1980, $709 million were from state and local non-Medicaid appropriations. Nor do public hospitals in general have many private patients to whom costs can be shifted—just 12 percent, on average, among NAPH members around the country.

Public Hospitals Have Managed Their Resources Efficiently.—A recent study by Alan Sager indicates that public hospitals have experienced the largest decrease in length of stay, and the only increase in occupancy rate, among all classes of hospitals in the nation's 52 largest cities. Moreover, public hospitals have decreased their total number of beds between 1970 and 1980—by over 22 percent—in those cities. In addition, most public hospitals are already managed and budgeted prospectively each year, with full, independent review by State and local governmental entities. Finally, such hospitals are often fully integrated institutions with salaried medical staff, and thus do not present many of the potential problems recognized recently by this Committee in separating hospital costs from physician costs.

The Non-Medicaid Uninsured Caseload of Public Hospitals has Substantially Increased in the Last Year.—The newly unemployed comprise just one part of the increased indigent caseload of public hospitals in metropolitan areas. The problem is substantially exacerbated by reductions in Medicaid eligibility, and inadequate funding for special populations such as illegal aliens and refugees. Moreover, we believe we can also anticipate a significant increase in more severely ill Medicare patients, as private hospitals move to adjust their caseload to maximize reimbursement under the new DRG system.

Public Hospitals are Important Providers of Primary and Ambulatory Care to Poor Persons Who Often Have Little or No Access to Private Physicians.—Just 23 of NAPH member hospitals had 5,254,839 outpatient visits and 2,150,855 emergency room visits in 1980 alone. A new, as yet incomplete survey of NAPH members' current experience in providing outpatient care indicates the following level of activity in several public hospitals around the country:

1982 OPD/ER visits

	Number
Bronx Municipal Hospital	588,037
Westchester County Medical Center	79,740
Seattle Public Health Hospital	112,602
Bellevue Hospital	522,719
St. Louis County Hospital	62,597
L.A. County/USC Medical Center	400,809
Highland General Hospital (Oakland)	108,843
King/Drew Medical Center (Los Angeles)	184,843
University Hospital/Newark	130,232
Cook County Hospital	584,208
Parkland Memorial Hospital (Dallas)	411,387

Expenditures for OP/ER debt/charity care at 18 of our hospitals totalled $193.3 million during 1982, or an average of $10.7 million per facility. This average represents roughly half of all outpatient care expenditures at these NAPH institutions.

In many cases, these figures represent a substantial increase in outpatient caseload over previous years. Clearly, where public hospitals exist, they have demonstarted the commitment and capacity to provide needed outpatient services for unemployed persons.

Most Public Hospitals in Metropolitan Areas Also Provide Specialized Inpatient, Public Health and Other Unique Services.—These services are often too costly or too "unreimbursable" for most private hospitals to maintain. They include burn units—trauma centers—emergency alcoholism, drug abuse, and child abuse centers—neonatal intensive care—poison control units—to name just a few. New NAPH data for 1982 shows that just 17 of our hospitals attributed 917,120 inpatient days to bad debt or charity care, or nearly 54,000 per hospital. Expenditures for unreimbursed inpatient care for just 20 of our members totalled $379 million in 1982, or nearly $19 million per hospital.

THE SITUATION IN MEMPHIS

I would like to bring you up-to-date on the situation as it exists today in Memphis, and more specifically at the Regional Medical Center of Memphis—what we are doing to fulfill our obligations to the community, and what else we must do to meet new obligations. Simply stated, the purpose of Regional Medical Center of Memphis is to provide high quality medical care to the citizens of Shelby County and the surrounding region, and to provide access to that quality care regardless of the patients' ability to pay.

Regional Medical Center of Memphis is not just a charity hospital. It is a community resource providing professional, medical, para-medical, and public health education for the community at large—education that develops highly skilled medical professionals, as well as medical and nutritional knowledge in the community that can prevent medical problems or their recurrence. Our special units are regarded as centers of excellence in such areas as trauma . . . obstetrics/gynecology . . . newborn care. Not only do we provide the finest medical care in these areas, but greatly increase the body of medical knowledge and provide an opportunity for development of higher, more advanced medical skills. Our OB-GYN unit has delivered more babies than all the other hospitals in the area combined. Last year our newborn center admitted 1,300 babies for special care, 3-4 times the number of admissions by other hospitals on average. It is highly acclaimed for both the quantity and particularly the quality of care. A unique aspect of the care provided by our Newborn Center is the Mobile Intensive Care Unit. This unit sustains infant life while transporting newborns from other hospitals and remote areas to Regional Medical Center of Memphis. And our trauma team is saving lives because of the development and practice of new trauma techniques—techniques developed at other public hospital trauma centers and in our own.

As you can see, our purpose goes far beyond providing high quality medical care to anyone. The Regional Medical Center of Memphis is a vitally necessary community resource. However, we are caught in an ever-tightening vise. Like other large public hospitals throughout the country, we are caught between an ever-increasing demand for our services and shrinking resources. It is a vise caused in part by the economic recession and in part by policies formulated at the federal and state level.

At the national level, there are more than 11 million workers who have lost their jobs—and along with the jobs, their health insurance. In the mid-south, our service area, more than 38,000 jobs have been lost along with their attendant health insurance benefits. And who can these thousands turn to for their medical care? Virtually alone among area hospitals, the Regional Medical Center of Memphis is the only place they know they will not be turned away for financial reasons.

These new job-losers are in addition to the over 162,000 people in our area with incomes at or below the poverty level who consistently have to turn to public care facilities, usually us, when they are in need of medical care. In our fiscal years 1981 and 1982, we treated 71,000 medically indigent inpatients and outpatients at Regional Medical Center of Memphis. In the current fiscal year, we estimate treating nearly 75,000 patients.

Our cost to provide health care to these medically indigent patients in 1982-83 will be $29,800,000. This represents a 33% increase over 1981-82. Additionally, we are treating more out-of-sate indigent patients from Arkansas and Mississippi than ever before—an increase of 21.5 percent for inpatients alone. While these other states do reimburse us for their care, the amount they pay by no means covers the cost of this care.

But this increasing demand for our services is only one jaw of the vise in which we find ourselves. The other jaw is one of shrinking resources. First and foremost of these is Medicaid payments. In the current fuscal year, Tennessee adopted a 14-day inpatient limit on annual Medicaid services; this resulted in a $3.5 million cash reduction for our hospital alone. For fiscal 1984 this loss will increase to $4.0 million and continue to compound the hospital's cash flow problem. The cash problem will be further intensified as a result of private hospitals dumping their medicaid patients on us because of the reductions instituted by the Medicaid program.

The government is not the only factor in our shrinking resources. Another part of this jaw of the vise is the increased competition among private hospitals for paying patients. These patients are either Medicare-eligible, carry privately purchased or company provided health insurance, or they simply have the resorces to pay for their medical needs. We have seen a continuing media blitz in our area by private hospitals, directed towards attracting more of these paying patients. There are more ads, commercials and billboards being run by the private hospitals than ever before. As they attract the paying patients, they continue to transfer the indigent and Medicaid patients to the Regional Medical Center of Memphis.

A more recent development is the establishment of freestanding emergency rooms, which are also engaged in a media blitz to attract the paying patient. While, by themselves, these free-standing emergency rooms should not be considered competition to hospital emergency rooms for serious emergencies, consider how important the emergency room is to the fiscal health of a hospital. Nationally, an average of 35 to 45 percent of a hospital's entire gross revenues are derived directly or indirectly from the emergency room operation. In reality, the emergency room is the front door of our hospital. At Regional Medical Center of Memphis, fully 73% of our revenues from paying patients are dependent on the Chandler and Crump Emergency Rooms. And what is happing in our emergency room? Our medically indigent patient load has increased from 35.9% in 1982 to 37.6% in 1983. We are indeed caught in a vise between an increased demand for our services and shrinking revenue sources. How are we handling it?

Nationwide, hospital operating costs continue to spiral upwards an average rate of 12 to 14 percent annually. That's for all hospitals—public and private. Public hospitals, however, continue to experience annual cost increases of 9.8 percent per year. Yet, Regional Medical Center of Memphis is projected to experience only a 2.5 percent operating cost increase this year. And while we've held down our operating costs, we've actually increased our services to the community by 4 percent. To increase service and hold down operational costs in the face of increased indigent load and decreased federal resources has not been easy. We've only been able to do it through increased management efficiency and improved medical care which has resulted in a decrease in the length of stay by patients and an occupancy increase. It has been more difficult because much of our occupancy increase has come from non-paying patients. And these medically indigent patients are sicker and often have multiple diagnoses and require more intensive, expensive care, than private patients. In addition, poor patients also require a wide range of other, non-medical services such as social workers and specially trained discharge planners which add substantially to the cost of their care.

Despite our clear gains in management efficiency—in large part due to our reorganization of the old City Hospital under a now not-for-profit corporate charter in 1981—we continue to experience serious fiscal problems. In our first year under this new arrangement (1981), we were given a city appropriation of $21.1 million. Our objective was simply survival of the hospital, and we needed an additional $11.3 million from the county government to keep the doors open and maintain quality care. In our second year we received a slighly higher appropriation, even though it didn't nearly approach the cost increases and patient load we were experiencing. And we still needed help to maintain the quality of care and the access to that care. Yet the recessionary pressures on the local governments which support us have been especially harsh, with 10.4 percent unemployment in Memphis. And now in our third year of management, we are expected to maintain or increase the quality of care and access to that care with resources that are dwindling, rather than growing. It simply can't be done.

If additional funding is not forthcoming, we do have some alternatives open to us. We can find new revenue sources to make up the difference. The new Presley Trauma Center can provide additional revenues, as it will attract insured and paying patients from other hospitals as well as from the public at large. We can attract additional revenues through our preferred provider program which is currently being implemented. We contract with organizations and employers to provide health services within the scope of their insurance plans and obsorb the cost of the individual's non-covered charges on their insurance. Currently this program is planned for implementation on July 1, 1983 at the hospital. The potential revenue may range up to $2 million. And by aggressively marketing our centers of excellence—improving the image of Regional Medical Center of Memphis as not just a charity hospital, but a hospital offering unparalleled medical excellence—we can hopefully attract a much greater number of insured, paying patients. We are about to open our new facility—a $70 million building with over 250,000 square feet. It will take personnel, equipment and money to bring this new facility into being. The alternatives of new revenue sources still cost money. Expenditures—media dollars—sales costs. Yet even all of these options—trauma center, preferred provider arrangements, an new image—are unlikely to provide enough revenue to bridge the budget gap if we are to continue serving all who need care. Therefore, what is left? More cost cutting. We can close 148 beds. And lay off 400 personnel. That would save $6 to $7 million and allow us to operate almost within our projected 23.5 million dollar budget deficit. However, community health services would be reduced to dangerously low levels, and we may not have the capacity to serve all people who need care. We could take a long hard look at the Regional Medical Center of Memphis Emergency Room—and possibly close it. That would save us $2.5 million to $3.5 million a year, from a projected need of $30 million. But, as I said earlier, 73 percent of our gross revenues are directly or indirectly generated via the emergency room. And many of our indigent patients rely on it as well. It would be self-defeating, a denial of the very purpose for the existence of Regional Medical Center of Memphis, to provide the effective medical care to everyone, regardless of their ability to pay. Today we are caught in the vise of increased demand for our services on one side with shrinking resources on the other.

The Regional Medical Center of Memphis is not a charity hospital. It is a community resource. For it to continue in its present role and to grow to be an even more viable and vital member of the community, three factors must be taken into account. Cost, quality and access. It's a triad of forces that always interact and impact upon one another. If you deal with cost control, this has a way of adversely affecting quality and access. If you are striving for quality, you need money—then access negatively affects both of these. If you are trying to deal with access—you've got to have money—and that places an imposition on quality. These three forces are often mutually competitive. The Regional Medical Center of Memphis is caught in the middle. We didn't create the conditions that are producing the increased need for medical care. We—and our patients—should not be made to bear the sins of the health care system, government policies and the general state of the economy, We have reached a point where we may soon no longer be able to afford the quality of care we are now able to provide—particularly for the indigent patient. Congress can clearly help us through the current crisis in Memphis, by enacting legislation before you today, and by increasing your attention to the health needs of all uninsured indigents—not just the unemployed. Without that support, it is by no means as clear that our community resource, the Regional Medical Center of Memphis can survive.

CURRENT EFFORTS TO ASSIST THE UNEMPLOYED

Earlier this year, Mr. Chairman, NAPH reported on voluntary private sector efforts to serve the unemployed. NAPH witnesses testified that it appeared admirable that representatives of the private health sector—physicians, private hospitals and other providers—had come forward with plans to provide services free or at a reduced rate to the unemployed. Programs cited as among the more successful, however, were almost all in those areas (Pennsylvania, Portland, Northern Virginia) with no public hospitals. We reported that we had identified relatively few of these efforts in areas where public hospitals also existed, and indeed that our members in areas of high unemployment had encountered significantly increased pressures to accept transferred patients. In some areas private hospital emergency rooms have been closed and signs posted demanding large deposits from the uninsured poor. NAPH also reported that some private hospitals had gone so far as to print maps and instructions for uninsured patients directing them to the County hospital.

We referred at that time to a map provided by a hospital in Bakersfield, California (unemployment rate: 14.9 percent, and we have subsequently seen additional examples. I have attached one such example to my testimony, which provides instructions directing indigent emergency room patients in a private Santa Monica, California hospital to take a 2½ hour trip on public transportation to get to the nearest public hospital, in Long Beach. In effect, this would be the equivalent of a hospital in Wilmington, Delaware, referring a patient to Newark for care.

In response to this disturbing trend, I would like to take this opportunity to repeat an important message to our uninsured citizens, regardless of the cause of their indigency:

No matter what funding decisions are made in the Congress, or by the States, regarding additional support for health services, where public hospitals continue to exist, we will use every resource available to keep our doors open. It is clearly our mission to provide this care, and we continue to do so with a substantial reliance on local taxpayer support. But as I have testified, many of us cannot long continue to provide the poor with our present level of services without the humanitarian assistance of our private sector colleagues—and significant additional support from the federal government as well.

COMMENTS ON PROPOSED LEGISLATION

For this reason, Mr. Chairman, we strongly urge the speedy adoption by this Committee and the full Congress of legislation providing that additional support. We testified nearly two months ago before the House Energy and Commerce Committee expressing our strong support for the bill ultimately reported out of that Committee as H.R. 3021. We expressed several concerns about that legislation as it was originally introduced, and we are pleased to note that virtually every one of those concerns was taken into account during the Committee's markup of that bill.

We are especially gratified at the Energy and Commerce Committee's clear recognition of the need for a direct grant program for public hospitals, and others serving substantial numbers of low income, uninsured patients regardless of their previous employment status. For while the unemployed do represent a significant problem for our nation's health care system, they are but one segment of the 22 million people who lack any form of health insurance in our nation today, and of the 20 million additional Americans whose insurance is inadequate.

In addition to H.R. 3021, we were also asked this week by Representative Rangel to comment on a proposal outlining a somewhat different approach to addressing the health needs of the unemployed. We are also aware that you will have before you legislation sponsored by Representative Frenzel and others to provide for an even simpler block grant to the States. We would like to make the following general observations about these proposals:

First, we would like to repeat that we continue to support H.R. 3021. While there may be equally viable alternatives, we believe this bill has been carefully and sensitively crafted to address the health needs of the unemployed.

Second, while we believe that any legislation which provides resources to meet these health needs is better than no legislation, we believe the Congress must provide some explicit guidance to States in the administration of such a program and would thus urge the Committee not to adopt a block grant proposal that lacks such guidance. As between "block grant" proposals, we would thus strongly prefer the one outlined by Representative Rangel, and if this approach is considered, would further urge the Committee not to adopt the policy option that would leave complete discretion to the States.

Third, with regard to the elements of Representative Rangel's proposal intended to target this assistance more specifically on the low income unemployed, including one-parent families and families with children, we would be doing a disservice to our mission as public hospitals, and the patients we serve, if we did not agree with you that this is clearly the population whose needs will be greatest. We also strongly approve of the expressed intention of including the public hospital grant program in your proposal as well.

Fourth, with regard to the suggested benefit package, we would question whether there will be sufficient resources—even at the House-passed budget level—to provide full funding of unlimited hospital days, although we agree that in some catastrophic cases, a single uninsured patient can wreak more havoc with a public hospital budget than a large number of more routine cases. The routine cases do continue to be an important part of the burden of serving the uninsured, however, and particularly in the area of ambulatory care and prenatal, deliver, and postpartum care. We would be concerned if these services were included in any catastrophic deductible.

Fifth, we would repeat a substantial concern we expressed in the Energy and Commerce Committee, that if for some reason (fiscal or otherwise) a state refuses to participate in a program, a heavily impacted local governmental entity should be permitted to participate in the program instead, rather than reallocating all of that State's funds elsewhere.

Whichever option you choose, Mr. Chairman, we urge you to act quickly. This legislation is even more essential today than it was when consideration began earlier this year. The few tantalizing glimpses we've seen of possible economic recovery are a long way from improving the lot of the indigent and unemployed in many of our metropolitan areas, including Memphis, where unemployment remains at 10.4 percent. And as you well know, some segments of American industry will never recover from the economic events of recent years.

Finally, I would just like to note in passing that our segment of the health care industry agrees that health costs in this country are still inflating far too rapidly for the good of our economy. The cost projections for Medicare and Medicaid, even with recent reimbursement reforms, remain intolerably high, with huge deficits projected in a very few years. The greater tragedy, however, is that we must cope with the prospect of these deficits at a time when we still do far less than most other civilized countries to guarantee a minimum level of health care to all our nation's citizens, including the elderly and poor. We urge you to speedily enact this vital legislation before you today to close one small part of that gap—and we promise to work closely with you in the future to address both parts of the equation: increasing costs—and inadequate access.

Thank you again, Mr. Chairman, for this opportunity to testify. We would be happy to answer any questions you may have at this time.

[Attachment]

DIRECTIONS FROM SANTA MONICA HOSPITAL EMERGENCY ROOM TO HARBOR GENERAL HOSPITAL IN TORRANCE, CALIF.

By car: Santa Monica FWY east to San Diego FWY south to Harbor FWY south. Exit from Harbor FWY at Carson Ave. Turn right to Harbor General Hospital, 1000 W. Carson Ave., Torrance, Calif. (213) 533-3533.

By bus: (16th St. and Wilshire Blvd., Santa Monica) via RTD bus and Torrance bus. Information 626-4455. Ask for transfer when boarding bus line.

RTD No. 20 or No. 308 east on Wilshire Blvd., to downtown Los Angeles.

Exit bus at 7th and Hill. Walk south 2 blocks to 9th St. On 9th St. between Hill and Broadway—take the No. 1 Torrance Bus Line Express. The Torrance Bus Line No. 1 has express service all the way to Harbor General.

Approximate bus fare for the entire trip, $1.10. Travel time 2½ hours. Or ask for transfer when boarding bus line.

RTD No. 20 or No. 308 east on Wilshire Blvd. to Westwood Blvd. Exit on Westwood. Take the No. 88 south on Westwood to the LAX terminal. Exit at 98th St. and Vicksburg (LAX terminal—Los Angeles Airport). Take No. 32 bus from LAX to Pacific Coast Highway and Torrance Blvd. Exit at PCH and Torrance Blvd. Take No. 3 Torrance bus east on Torrance Blvd. to Harbor General Hospital, 1000 W. Carson Blvd.,Torrance CA. (213) 533-3533.

Approximate bus fare for the entire trip, $1.00. Travel time, 2½ hours.

RTD bus fare is 50¢. Always ask for transfer which is 10¢.

Dated: November 1982.

Chairman Ford. Mr. Owen.

STATEMENT OF JACK W. OWEN, EXECUTIVE VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION

Mr. Owen. Thank you, Mr. Chairman.

My testimony has been submitted. In deference to time, I will just summarize some of the points we feel strongly about.

First of all, I agree with Mr. Sowa, that the problems facing intercity hospitals and many other hospitals in areas where high unemployment is taking place are extremely difficult ones.

They carry substantial bad debt and charity loads that are threatening their financial viability. There is no such thing as free care. We have to pay for food and supplies, and we have to pay for the nurses and people who take care of those patients.

So we feel that there should be congressional action quickly on this bill to assist hospitals that are dedicated to serving the unemployed.

Without public as well as private efforts, we fear that many people will postpone needed medical care, particularly preventative and prenatal services. We are already beginning to see some increases in stress-related illnesses and infant mortality rates, especially in areas of high unemployment.

We have some specific recommendations in our testimony regarding the basic outlines of a Federal program. I would like to summarize these briefly.

We strongly support creation of a Federal program designed to assist insurers and providers of health care to continue providing quality care to displaced workers and their families.

The public and private sectors must share responsibility for these workers equally. Federal effort should not displace this responsibility nor act as a disincentive for innovative private sector approaches.

Federal legislation must be flexible and should encourage State and local governments in partnership with the private sector to target aid quickly and efficiently to areas of greatest need.

More specifically, AHA believes that Federal legislation should adhere to the following general legislative guidelines:

First, States should seek to cover as many unemployed workers and their dependents as financially feasible and limit the program as a payor of less resort. I think that was discussed this morning, and we would concur that this program should not cover until all of their financial means and insurances are used.

Second, beneficiary contributions: States should be given the option to require some premium contributions and cost sharing, but they have to be modest and cannot become a disincentive to health care coverage.

Third, means test: We don't think there should be a means test as a condition for eligibility. The program should provide health care support to workers and their families unable to afford such coverage, and should not be structured as a welfare program. A means test would mean they would have to sell their automobiles and liquidate some of their other assets to get health coverage.

Fourth, the program should encourage coverage of prenatal services, limited inpatient/outpatient hospital care and should contain a catastrophic illness component.

Lastly, a sunset provision is essential to encourage ongoing congressional review of the programs. We must avoid setting up a mechanism which encumbers States with long-term obligations for which they lack adequate resources. I think we heard just a minute ago about some of the lack of States in meeting their financial needs for the poor and needy, let alone the unemployed.

Now, as far as the block grant and entitlement program, we support the block grant concept embodied in the Frenzel bill because of the flexibility it offers. However, we are concerned that there are no minimum safeguards or specific benefits in the bill.

We do support the inclusion of specific provisions which outline eligibility, benefits, length of coverage, cost sharing similar to those included in the Waxman-Madigan bill.

What I am saying is both of these bills from our standpoint are not that bad, but that there should be some actions taken. It is important that action be taken.

The practicality of whether the programs are going to be run through a medicaid mechanism or whether the programs are going to be run through an unemployment mechanism is a problem of mechanics, rather than one of how this bill gets enacted.

Last, in financing, we have supported a revenue cap on premium benefits. We think that is one way that this can provide the revenue to support this bill. We support this cap for a couple of reasons—the most important reason that it will tend to get people to look at why they spend money on health care.

Excessive health benefits are inflationary. There is no question about it. If they insulate the provider and the carrier, they encourage overuse of health services.

A cap would make them more cost conscious and encourage them to demand more cost effective care as well as less costly service. Reducing the rate of inflation in the health care sector requires addressing not only medicaid and medicare outlays but also private health spending.

We stand ready to help the committee in any way we can. We hope that you will act promptly on this legislation before you.

Thank you.

Chairman FORD. Thank you very much.

[The prepared statement follows:]

STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION

The American Hospital Association, on behalf of its 6,300 institutional and 35,000 personal members, is pleased to present its views on health insurance coverage for unemployed workers. This issue is one of priority interest to health care providers, as well as many others in the private and public sectors who have faced the problems of assuring continuity of community health care during the recent period of sustained high unemployment.

The AHA commends the efforts of these Subcommittees and other Committees in Congress to provide some form of assistance to those who have lost job-related health insurance benefits. But we believe the need for federal assistance is urgent. We hope that both Senate and House Committees looking into this problem will soon agree on a unified, bipartisan approach and move Congress quickly toward enactment of a program to assist states and local communities in their efforts to provide assistance to unemployed workers and their families who are in need of health care coverage.

At the present time, many communities, hospitals, physicians, insurers, businesses, and labor organizations are making special efforts to meet the needs of this population group. State and local governments also have joined or supported these voluntary initiatives in many instances. The point we would emphasize is that federal legislative efforts should build on and support local initiatives already in place, ensuring that federal programs do not displace private-sector and state and local government programs.

NATURE AND SIGNIFICANCE OF THE PROBLEM

Approximately 12.4 million Americans, or more than 10 percent of the labor force, currently are unemployed. Even with improving economic conditions, high levels of unemployment are expected to continue for several years. The Congressional Budget Office (CBO) indicates, for example, that unemployment rates will exceed 9 percent through 1985. With over 90 percent of the private, non-farm labor force receiving health insurance benefits through employment, the great majority of the unemployed—an estimated 14 million to 21 million individuals, according to CBO—are without health insurance protection.

For most of the unemployed, the question is not one of access to health care services but the cost of such care. Many who formerly purchased coverage for themselves and their families no longer are financially able to do so. They allot limited resources to other necessities such as food, shelter, and clothing. In addition, loss of employment means a loss of eligibility for group insurance rates and employer contributions. According to Alexander and Alexander's Human Resources Management Groups, the annual premium for the worker who converts from group coverage to individual coverage averages $1,200 to $1,800 a year. An unemployed individual receiving insurance benefits surely cannot afford such coverage.

It should be noted that, within the broader issue posed by loss of employment-related health benefits, there are two separate problems. The first pertains to the "temporarily" unemployed, persons for whom there is a reasonable prospect of regaining employment-related health benefits as the economy recovers. For these persons, public and private actions can provide effective interim means to assure continuance of needed health services. The second problem pertains to the "structurally" unemployed, persons who are unlikely to be rehired because of fundamental economic problems in a particular industry. Assuring availability of health care (and other necessities) for these persons is likely to require a longer-term response in the form of economic assistance and employment retraining.

For either group, health problems could be substantial and are cause for concern. Many unemployed workers, for example, are postponing needed medical care because of lost health insurance. That circumstance, particularly with regard to preventive, prenatal, and post-partum services, ultimately will cause more severe and costlier health problems in the future. We fear that the incidence of stress-related illnesses among the unemployed is already on the rise, and infant mortality rates, especially in high-unemployment communities, have increased. In Michigan, the state with the highest unemployment rate in the country, the infant death rate rose 3 percent from 1980 to 1981—from 12.8 deaths to 13.2 deaths per 1,000 live births. In the same period, the national rate declined by 6.4 percent, to 11.6 deaths per 1,000 live births.

Hospitals and other health care providers share the nation's concern over such setbacks in community health. We regard the human suffering that has resulted as intolerable and foresee long-term effects on community health resources. In the face of high interest rates and general economic pressures, coupled with substantial reductions in payment levels under Medicaid and other federal programs, hospitals and physicians have limited resources with which to respond to a growing population of under-insured and uninsured. Rising levels of bad debts and charity care, which are not recognized by Medicare and Medicaid, are threatening the financial viability of some providers. Generally, hospitals that traditionally have provided substantial services to the publicly sponsored and indigent populations in their communities bear an inordinate share of the problem. A study conducted jointly by AHA and the Urban Institute—a survey of 453 hospitals of which 13.3 percent were public facilities—indicates that large public hospitals averaged about $32.8 million in free care to the poor, compared with $16.8 million for small public hospitals, $9.5 million for large private hospitals, and $3.4 million for small private hospitals.

The situation presages a significant long-term problem of gradual but substantial erosion of health resources in economically depressed communities, particularly inner-city areas. It will be difficult and costly to restore these lost resources, even with substantial improvement in the economy.

RECOMMENDATIONS

The AHA strongly supports creation of a federal program designed to assist insurers and providers of health care to continue providing quality care to displaced workers and their families. The public and private sectors must share responsibility for these workers equally; federal efforts should not displace this responsibility nor acts as a disincentive for innovative private-sector approaches. Federal legislation must be flexible and should encourage state and local governments in partnership with the private sector to target aid quickly and efficiently to communities with the greatest need. We believe that federal legislation should adhere to the following general guidelines:

Public and private sector responsibility: Federal efforts should not create a regulatory structure that will act as a substitute for creative state and local government or private sector initiatives, but instead act to complement efforts already underway.

Flexibility: States should be encouraged to develop programs that target aid quickly and efficiently to communities with the greatest need. For example, capitation arrangements between state and local governments and providers of health care services should be encouraged.

Eligibility: States should seek to cover as many unemployed workers and their dependents as financially feasible and should limit the program to "payer of last resort."

Beneficiary contribution: States should be given the option to require premium contributions and cost-sharing by beneficiaries. These payments should be modest, however, and not become a disincentive to health care coverage.

Means test: Means testing should not be required as a condition for eligibility. The program should provide health care support to workers and their families unable to afford such coverage; it should not be structured as a welfare program.

Benefits: The program should encourage coverage of preventive services, especially among young children; prenatal and post-partum care; and limited inpatient and outpatient emergency hospital care. It also should contain a catastrophic illness component.

"Sunset" provision: A "sunset" provision is essential to encourage on-going Congression and public review of the program. Setting up a mechanism which encumbers states with long term obligations for which they lack adequate resoures must be avoided.

BLOCK GRANT VS. ENTITLEMENT

At the present time, there is some disagreement over the approach that should be taken when developing a federal program to assist unemployed workers in securing health care protection. One bill, H.R. 2552, sponsored jointly by Representatives Henry Waxman and Edward Madigan, proposes a Medicaid-based approach whereby states could voluntarily opt into a federal-state matching grant program that would require minimum standards for eligibility, benefits, length of coverage, and beneficiary contributions. On the other hand, H.R. 3183, sponsored by Representative Bill Frenzel, authorizes a federal block grant to states but requires no minimum conditions for state participation. The Frenzel bill demands no state matching payments and leaves total discretion to states in designing program outlines.

In general, AHA supports the approach of the Frenzel bill, particularly regarding the flexibility offered by the block grant. We are, however, concerned that no minimum safeguards are set forth in the legislation. We fear this could lead to the creation of 50 different programs across the nation without assuring adequate levels of coverage. AHA believes that state flexibility is vitally important to encourge innovation, quick action, and an appropriate mix of federal, state, and private-sector resources. But such flexibility should not jeopardize the basic purpose and goals of the legislation. If federal assistance is provided, and we encourage Congress to do so, minimum standards must be set forth in the bill to assure geographic fairness and continuity of coverage.

The Waxman-Madigan bill is quite specific in this regard. AHA strongly supports inclusion of several Waxman-Madigan provisions, particularly the eligibility criteria, benefits, length of coverage, beneficiary cost-sharing limits, and the public hospital grant program. Our concerns regarding the bill relate primarily to its entitlement aspects and to the use of state Medicaid agencies as the primary administrative vehicle. AHA believes that Congress must avoid setting up a program which encumbers states with long-term obligations for which they lack adequate resources. The block grant approach would not create these long term problems and would encourage on-going Congressional and public review. We also fear that the Medicaid link may act as a disincentive for state, local, and private sector initiatives and jeopardize the concept of co-responsibility.

FINANCING

Perhaps the most important concern over the health insurance for the jobless issue has been the question of how to provide revenues to finance this program. The AHA believes that one option that should be seriously considered is using revenues from a cap that would limit tax-free employer-paid health benefits to $175 per month for a family plan and $70 per month for an individual employee plan. This proposal, endorsed by the Administration and introduced by Representative Conable at H.R. 2575, would generate substantial revenues, estimated at $2.1 billion in fiscal year 1984, $4.2 billion in fiscal year 1985, $6.0 billion in fiscal year 1986, $8.0 billion in fiscal year 1987, and $10.7 billion in fiscal year 1988.

While the tax system should be designed to encourage employers to provide an adequate level of health benefits to their employees, the tax preference should not be open-ended. Individuals whose employer contributions exceed the limit would maintain their current insurance levels with "after-tax" dollars, but this policy would not encourage them to buy more insurance.

Excessive health benefits are inflationary; they insulate consumers, providers, and insurers from the cost consequences of health care decisions, contributing to both the use of inefficient forms of health care financing and delivery, and to the overuse of health services. A cap would remove the insulation that separates consumers from actual health costs, making them more cost conscious and encouraging them to demand more cost-effective care as well as less costly services.

It is also important to note that such a cap would have a progressive impact. The average tax benefit from current law is directly related to current income—the higher one's income, the larger the tax subsidy for health benefits.

Reducing the rate of inflation in the health care sector requires addressing not only Medicare and Medicaid outlays but also private health spending. The limit on tax-free benefits would help address these issues without reducing an individual's opportunity for protection against the serious financial consequences of illness.

While we believe that the tax cap proposal is good health and tax policy, we also feel it is appropriate that the revenues realized from this proposal be used to finance health care for the unemployed.

CONCLUSION

Again, we commend the efforts of all the Committees in Congress looking into the problems of health care coverage for unemployed workers. AHA believes that the need for federal assistance is urgent but that any program must be flexible to encourage and support development of private-sector initiatives. AHA believes that state and local governments, with the cooperation of local employers, labor unions, and health care providers, should be allowed to choose among various approaches—state insurance pools, Medicaid, capitation, or vouchers—in order to serve the health care needs of this population group.

We stand ready to assist the Committee and lend our support to those efforts.

Chairman FORD. The American Medical Association.

STATEMENT OF JERALD R. SCHENKEN, M.D., VICE CHAIRMAN, COUNCIL ON LEGISLATION, AMERICAN MEDICAL ASSOCIATION, ACCOMPANIED BY ROSS RUBIN, DIRECTOR, DEPARTMENT OF FEDERAL LEGISLATION, DIVISION OF LEGISLATIVE ACTIVITIES

Dr. SCHENKEN. Thank you, Mr. Chairman.

My name is Jerald R. Schenken, M.D. I am a physician in the practice of pathology in Omaha, Nebr., and vice chairman of the AMA's Council on Legislation. With me is Ross Rubin, director of AMA's Department of Federal Legislation of AMA's Division of Legislation Activities.

The problem of health care and health insurance coverage for the unemployed is not new. In fact, this is not the first time that this issue has been addressed by the Congress. In 1975, with national unemployment in the 8-percent range, legislation was introduced and major hearings were held on this very same subject.

The American Medical Association at that time endorsed Federal efforts for a short-term program to provide health benefit coverage for the unemployed.

What is new, Mr. Chairman, are the high levels of unemployment facing the Nation as a whole and in specific areas of the country where unemployment nearly doubles the national rate.

There are millions who face the loss of medical care coverage for themselves and their families—including their children who need regular medical supervision.

The effect of these economic circumstances can be widespread. During such times, families must defer health expenditures, and they live in fear of incurring health expenses which may leave them in debt for an extended future period.

Health care institutiuons are also affected and can be placed in serious fiscal jeopardy. Health insurance plans, faced with loss of membership, are less able to spread risks. There is an increasing impact across the entire health industry.

Existing Federal programs, including medicare and medicaid, provide specific health care benefits to targeted populations. State and local programs often provide health care services or coverage to those who do not qualify for Federal programs, such as medicare and medicaid, but generally such assistance is limited to those who are without assets or other financial means.

The newly unemployed person rarely fits into one of these categories. Unfortunately, because of their loss of income and because of the higher cost of individual health insurance policies compared to group benefit plans, many unemployed individuals cannot afford to cover adequately the expected health insurance needs of their families.

It is specifically this group, then, that needs to be addressed. It is for this group that a bridge should be built to provide coverage for an interim period until the individual can become employed again and receive employment-based health insurance benefits.

For some time the AMA has been active in encouraging individual physicians, State and local medical societies, and national medical specialty societies to develop voluntary programs to insure continuation of health care to the unemployed and their families who are in need of such care.

Many physicians have assisted unemployed patients in meeting their health care needs and recent information indicates medical societies and the health community have become more active in initiating programs to assist the unemployed. We are proud of these initiatives and are encouraging more and more societies and physicians to follow suit.

However, the scope of the current unemployment problem and the length of the current recession indicate to us that a temporary nationwide program to provide health insurance for the unemployed is necessary and, therefore, the AMA supports the creation of a formal program to provide health insurance coverage for the unemployed.

In our view, such a program should be based on certain basic principles.

It should have limited eligibility, targeted among the unemployed.

While Government must have a role, the program should be administered in the private sector, providing private insurance coverage. It should not become enmeshed in the medicare or medicaid programs.

It should avoid disruption in continuity of care for the individual and his or her family and, to the extent possible, in continuity of health insurance coverage.

Financing should be a shared responsibility of government and the private sector.

It should provide benefits limited in scope, and provide for freedom of choice of providers.

It should be temporary and subject to early and ongoing congressional and public review and evaluation.

Detailed guidelines for such a program are discussed in our full statement.

In conclusion, Mr. Chairman, the American Medical Association has been actively involved in encouraging our members and other medical societies to provide health care for the unemployed. These activities will continue.

However, the scope of the problem, along with the expected duration of high levels of unemployment, indicate a need for a more formal and comprehensive way of dealing with this temporary situation.

We urge you to structure any program to encourage the use of the private sector, both in insurance underwriting and service delivery. Use of the private sector will avoid disruption of existing relationships among patients, physicians, insurors, and providers, thereby allowing for continuity of high quality care for families during the temporary period when an individual is unemployed.

Because of its inappropriate use of the medicaid program as the primary vehicle for delivery of services, and even though there are many features of the bill we would agree with, we cannot support H.R. 3021.

Mr. Chairman, I would be pleased to answer any questions the subcommittee may have.

Chairman Ford. Thank you very much.

[The prepared statement follows:]

STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION PRESENTED BY JERALD R. SCHENKEN, M.D.

Mr. Chairman and Members of the Subcommittees: My name is Jerald R. Schenken, M.D. I am a physician in the practice of pathology in Omaha, Nebraska, and Vice-Chairman of the AMA's Council on Legislation. With me is Ross Rubin, Director of AMA's Department of Federal Legislation.

The American Medical Association appreciates the opportunity to appear today to discuss the subject of health care and health insurance for the unemployed.

NATURE OF THE PROBLEM

The problem of health care and health inusrance coverage for the unemployed is no new. The United States has not achieved full employment for decades, and there has been a substantial level of unemployment among Americans over this time. In fact, this is not the first time that this issue has been addressed by the Congress. In 1975, with national unemployment in the 8% range, legislation was introduced and major hearings were held on this very same subject. The American Medical Association at that time endoresed federal efforts for a short-term program to provide health benefit coverage for the unemployed. What is new are the high levels of unemployment facing the nation as a whole and in specific areas of the country where unemployment nearly doubles the national rate.

Furthermore, knowledgeable analysts indicate the average length of unemployment during this recession has incraeased and that it is expected that a significant number of individuals will not be able to return to their previous jobs even during a national economic upturn. This extended unemployment problem has been recognized by the Congress through major extensions in coverage for unemployment compensation, including the extension of emergency benefits as part of the Social Security reform package. It has been estimated that some 5.3 million individuals have lost their jobs and their health insurance coverage. Thus there are millions who face the loss of medical care coverage for themselves and their families—including their children who need regular medical supervision. Furthermore, information indicates that the unemployed are often in need of more medical care due to the stress of unemployment. Mr. Chairman, we face a public health problem that must be addressed.

The effect of these economic circumstances can be widespread. During such times families must defer health expenditures, and there is concern that they might incur health expenses which may leave them in debt for an extended future period. Health care institutions are also affected and can be placed in serious fiscal jeopardy. Health insurance plans, faced with loss of membership, are less able to spread risks. There is an increasing impact across the entire health industry.

The current "crisis" relating to health insurance for the unemployed is a direct result of a very successful public policy that has encouraged employment-based health benefit plans. Approximately 90% of the non-farm U.S. workers receive health benefit plans through employer-based group policies, with their employer paying part or all of the premium. Therefore, when unemployment grows, the number of individuals who lose health insurance coverage increases.

Existing federal programs, including Medicare and Medicaid, provide specific health care benefits to targeted populations. State and local programs often provide health care services or coverage to those who do not qualify for federal programs, such as Medicare and Medicaid, but generally such assistance is limited to those who are without ssets or other financial means.

The newly-unemployed person rarely fits into one of these categories. When income from active employment ends, these individuals usually have significant assets, such as homes, cars and furnishings, that preclude their participation in either Medicaid or state and local general assistance programs. Unfortunately, because of their loss of income and because of the higher cost of individual health insurance policies compared to group benefit plans, many unemployed individuals cannot afford to cover adequately the expected health insurance needs of their families. It is the group, then, that needs to be addressed. It is for this group that a bridge should be built to provide coverage for an interim period until the individual can become employed again and receive employment-based health insurance benefits.

VOLUNTARY EFFORTS

For some time the AMA has been active in encouraging individual physicians, state and local medical societies, and national medical specialty societies to develop voluntary programs to ensure continuation of health care to the unemployed and their families who are in need of such care. Many physicians have assisted unemployed patients in meeting their health care needs. Seventy-nine percent of physicians surveyed by the AMA's Socioeconomic Monitoring System indicated that during October and November of 1982 they had treated patients who had lost their health insurance due to unemployment. Of those physicians treating patients who lost benefits due to unemployment, 71% provided care without charge or at reduced rates. Furthermore, at that time approximately 10% of all physicians were donating their services to some type of "fair share" program organized by community leaders and medical societies to provide services for those who have lost their primary source of income and do not qualify for government assistance.

Recent information indicates medical societies and the health community have become more active in initiating programs to assist the unemployed. To date we have catalogued 23 formal programs sponsored by medical societies or hospital medical staffs to assist the unemployed in receiving medical care. For example, as early as June 1981, the Wayne County Medical Society in Detroit, Michigan, began recruiting physicians to participate in a task force to ensure the availability of health care services for the recently unemployed. This program covers physicians from Detroit and Oakland County, which are especially hard hit by layoffs in the auto industry. Another example is the Harris County Medical Society in Houston, Texas, which has a program under which physicians provide free care in their offices or work in a public clinic for a day. This program has the participation of over 1000 of the Society's members.

In addition we are encouraging joint local efforts, whereby physicians and their societies, together with hospitals and their associations and insurers may provide temporary programs to make limited insurance coverage and service available to the unemployed and their families.

We are proud of these initiatives and are encouraging more and more societies and physicians to follow suit. However, the scope of the current unemployment problem and the length of the current recession indicate to us that a temporary nationwide program to provide health insurance for the unemployed is necessary. This is especially true in light of the structural unemployment problems now facing the nation.

AMA GUIDELINES FOR A PROGRAM

Mr. Chairman, while the physicians individually, medical societies programs, joint local efforts, and state programs will help many of the unemployed with medical needs, the AMA supports for others the creation of a formal program to provide health insurance coverage for the unemployed. In our view such a program should be based on certain basic principles:

It should have limited eligibility, targeted among the unemployed.

While government must have a role, the program should encourage maximum participation by the private sector in the development and implementation of the program, be administered in the private sector, and provide private insurance coverage.

It should avoid disruption in continuity of care for the individual and his or her family and, to the extent possible, in continuity of health insurance coverage.

Financing should be a shared responsibility of government and the private sector.

It should provide limited benefits and provide for freedom of choice of providers.

It should establish a short-term solution for the temporarily unemployed and not create an entitlement program.

It should be subject to early and ongoing Congressional and public review and evaluation.

The elements of a program are discussed below.

Eligibility and coverage

We believe that eligibility for a program should include the following three categories of persons:

Persons who become unemployed after the law is enacted should be eligible during the period in which they have a right to receive regular, extended or federal supplemental unemployment compensation.

Persons who are unemployed and receiving unemployment compensation when the law is enacted should be eligible for a period equal to the total time in which they have a right to receive unemployment compensation. (This would include time before the law is enacted.)

Persons who are unemployed when the law is enacted and who have exhausted their right to unemployment compensation within the prior twelve months should be eligible for a period equal to the time during which they had a right to receive unemployment compensation.

In order to reduce program costs, we believe that certain individuals should not be eligible for coverage even if they fall into one of the above categories. Individuals should be excluded if they are eligible for continuation of an employer-offered health benefit plan or if they can receive health benefits through a family member who is eligible for employment-based coverage. In addition, persons who are eligible for Medicare, Medicaid, or other government programs should be required to use such coverage.

Administration

We believe that a program should be administered at the state level through the use of statewide private insurance pools. Each state would enact a law authorizing an insurance pool if necessary. The pool would write individual policies. The state unemployment compensation office should be used to identify eligible individuals. All insurers, including self-insured companies, that provide or make payment for medical care under a group health benefit plan in the state should be required to participate in the pool. If a private pool is not established in a state within 6 months after the law is enacted, the state insurance commissioner should be responsible for ensuring that the pool is established. The insurance commissioner should also approve premium rates and review information issued by the pool.

Until an insurance pool is formed in a state, the program should be administered by the states using the state's Medicaid or other existing agency program. However, from the outset, the program should provide private insurance coverage. The program should not become enmeshed with Medicare and Medicaid.

Financing

Program beneficiaries, the federal government, state governments and the insurers participating in the pools should finance the program. Unemployed individuals should pay a portion of the premium using a sliding scale based on total family income, both earned and unearned, of those covered by the policy. The premium should not exceed the actuarial value of the policy's benefits. Unemployed individuals should also pay deductibles and coinsurance for all covered services. The amount of such deductibles and coinsurance should be affordable based on the person's total family income. If the national unemployment rate exceeds a certain rate (e.g. 7%) and a state's unemployment rate exceeds that rate, the federal government should contribute to the pool based on a sliding scale related to the state's level of unemployment weighted by the covered population. This federal contribution would assist those states that are hardest hit by unemployment. States should also contribute to the pool in their state. Finally, if the pool's yearly expenses exceed federal and state payments and premium payments collected from unemployed persons, the pool should assess group health entities conducting business in the state for the shortfall based on each entity's activity in the state for that year.

Benefits

Any program should allow for free choice of provider, and benefits should be set at the state level. However, if a pool accepts federal funds it should be required to offer the following minimum benefits:

Specified inpatient hospital services (e.g., 14 days per year);

Emergency services;

Physicians' services including the following:

Outpatient services provided in a physician's office or clinic; inpatient services; prenatal, maternity and postpartum care; and diagnostic laboratory and radiology services.

All services covered should be medically necessary.

Tax Changes

Certain modifications in the tax laws could make a program more effective and reduce program costs. The AMA would support the following changes in the tax laws:

1. During the two-year period of the program employers should be required to purchase group health coverage from an entity participating in either a state or private insurance pool in order to be allowed to deduct the cost of group health insur-

ance premiums for its employees. Self-insureds should be required to participate in the pool in order to deduct the costs of their health benefit plans.

2. The actuarial value of the portion of the insurance premium not paid by the unemployed person should be considered taxable income if the person's or his family's adjusted gross income from other sources exceeds $25,000.

3. In order to deduct health insurance premiums, an employer must provide for a period of open enrollment of at least 30 days immediately after the loss of family member coverage of any person eligible to enroll in the plan was covered under a spouse's or parent's plan and lost coverage as a result of the unemployment of such person's spouse or parent.

Duration

In our view, the program should have a duration of only two years. This would provide the Congress and the nation an opportunity to evaluate the need for continuation of or modifications to the program on a scheduled basis to ensure that another "entitlement" program is not created.

H.R. 3021

H.R. 3021, introduced by Representative Henry Waxman (D–CA) and Edward Madigan (R-IL), would establish a three-year entitlement program in which health benefits would be provided to eligible unemployed persons and their families. The estimated cost of the program in fiscal year 1984 is $2.6 billion. State participation in the program would be optional. Federal matching funds would be provided to participating states based on their umemployment rate. Benefits would be limited and states could require cost-sharing by beneficiaries. States could provide health benefits through either a public program utilizing their Medicaid system, or through agreements with private health plans.

VIEW OF AMA CONCERNING H.R. 3021

H.R. 3021 inappropriately relies on state Medicaid programs for implementation of the program created. Although states would be authorized to provide coverage through private health plans, the bill presumes the use of the Medicaid system as the primary coverage mechanism. We believe that a program for providing health insurance for the unemployed should mandate private insurance coverage and private sector administration in order to have continuity of coverage if possible and to reduce the financial burden on government. Any use of state Medicaid systems should be limited to administrative purposes and then only until private insurance pools can be established. The Medicaid program in many states is already fraught with numerous problems. We believe that adding yet another group to this already troubled program would exacerbate existing problems. We also believe that use of the Medicaid system for the temporarily unemployed is especially inappropriate since it would force many families to break established relationship with their physicians. This would be particularly true in states that restrict beneficiary freedom-of-choice.

We are also opposed to H.R. 3021 because of the entitlement nature of the program. Currently, governments at all levels are financially strapped. As a result, we believe that the cost of a program to provide health insurance for the unemployed should not be open-ended.

CONCLUSION

The American Medical Association has been actively involved in encouraging our members and other medical societies to provide health care for the unemployed. These activities will continue. However, the scope of the problem, along with the expected duration of high levels of unemployment, indicate a need for a more formal and comprehensive method of dealing with this situation. We urge the Subcommittees to carefully consider the AMA guidelines for developing a program to provide health benefits for the unemployed. These guidelines rely on the private sector for underwriting, administration and service delivery. Use of the private sector will avoid disruption of existing relationships among patients, physicians, insurors and providers, thereby allowing for continuity of high quality care for families during the temporary period when an individual is unemployed.

Chairman **Ford**. First, Mr. Sowa, you describe the problem with the Regional Medical Center in our hometown. Would you think that would be somewhat of a description of other public urban hospitals faced with unemployment, like the 10.4 percent in our hometown? Would other hospitals be faced with the same problems you have described here?

Mr. **Sowa**. In conversations with other administrators around the country, it is uncanny; it is like looking at a mirror.

The other institutions, almost to the number, are facing the exact problems we are, both from the standpoint of county funding shortfalls, increased medically indigent care, and patient dumping. This seems to be a national trend.

Chairman **Ford**. Mr. Gage.

Mr. **Gage**. I would just add to that that in fact the situation Mr. Sowa describes is one in which his hospital is substantially better off than some of the other public hospitals around the country represented here today among the members, Mr. Gephardt, Mr. Moore, Charity Hospital in New Orleans, St. Louis Hospital, both are threatened with almost imminent danger of closure.

There have been press reports in those cities about hospitals in substantially worse shape right now than Memphis.

Chairman **Ford**. Mr. Sowa, even if the application that is before HHS now with the Secretary, increasing the medicaid days from 14 to 20, and given that you just take the Regional Medical Center in Memphis, to the tune of about $3 million additional dollars, without this legislation and with unemployment being as high as it is in our hometown, wouldn't it still create somewhat of a problem for the Regional Medical Center without——

Mr. **Sowa**. Yes, sir. We again, for the purposes of clarity, we have requested a waiver on our medical eligibility.

There is a current cap of 14 days. Through the Governor's office, a waiver request has been requested to increase for those hospitals that serve a disproportionate number of low-income poor people, the request from 14 days to 20 days, even with that, there are still uncertainties with private health insurance, for example, not paying the same as it had in the past.

Again, with patients being transferred from other private institutions because of no insurance, we still have grave concerns. Along with that, attendant with that, we are currently in our budget process in the county. There is somewhat of a disinclination to continue to fund the institutions at its current level, that they feel that there may need to be other things to be done.

Chairman **Ford**. Have you been able to trace any of that to the unemployment problem?

Talking about the dumping from private hospitals, as well as those patients that you receive at the Regional Medical Center without health coverage, have you seen increase in that since the unemployment rate has been up?

Mr. **Sowa**. Yes, sir. This year we are projecting approximately 300 transfers from other institutions. We do not have a set of questions for patients coming in that have been transferred, but in interviews we have found many of these individuals had insurance, had previously had insurance and had lost it, had gone to private institutions and, on finding they had no insurance, had been transferred.

Chairman **Ford**. Thank you.

Mr. Moore.

Mr. **Moore**. Thank you.

My good friend Mr. Owen continues to come forward in a very cooperative effort to attempt to help us with lowering costs. Thank you.

Chairman **Ford**. One final question.

Dr. Schenken, I listened to your testimony. The bill before the Congress, and also there is another alternative plan with the block grant, could I get you to comment on, if you are familiar with the Rangel plan that might be presented before the full committee, next week?

Dr. **Schenken**. I am not familiar with that plan, Mr. Chairman.

However, we would be supportive of the block grant concept, providing it would have the flexibility that we and many of the other witnesses, and some of your plans, have suggested to give the States to operate within their own guidelines. Again, these plans should provide for care in the private sector with freedom of choice of providers by the beneficiaries.

Chairman **Ford**. Thank you. The Chair would like to thank all of the witnesses who have appeared on the panel for coming and being a part of the hearing today. Thank you very much.

The Chair will recognize the Washington Business Group on Health, Mr. Willis B. Goldbeck, president; the National Federation of Independent Business, James D. "Mike" McKevitt, director of Federal legislation; the Chamber of Commerce of the United States, John Peter Ozga, director of health care, accompanied by Michael Romig, director of employee benefits; and National Association of Manufacturers, Mr. Donald T. Bliss, member of policy subcommittee on health care, accompanied by Sharon Canner, health care analyst.

Mr. Goldbeck.

STATEMENT OF WILLIS B. GOLDBECK, PRESIDENT, WASHINGTON BUSINESS GROUP ON HEALTH

Mr. **Goldbeck**. Thank you, Mr. Chairman. I am Willis B. Goldbeck. Our organization covers some 40 to 50 million insured lives. This is a national problem which, as we sit here and take pleasure in the improved unemployment statistics nationally, is getting worse rather than better. There was an inevitability to that because this is a problem which has a lagtime due to the rate at which people fall off already existing extended benefit plans.

One specific example would be a firm which had at the end of last year some 12,500 persons laid off. At the end of last year better than 10,300 still had corporately provided extended benefits. Today 10,100 of those 10,300 have fallen off their corporate extension. The problem is getting worse in that sense even though there are no new unemployeds or laid off persons coming from that individual corporation.

This is not an issue unlike many others you face where there is someone to blame but only people to help. From the standpoint of our members the top priority in the Nation is to get the economic recovery back on track. That will not be accomplished by driving further millions of former workers and taxpayers deeper into poverty in order to gain access to already virtually bankrupt public programs. This is not a problem that can be solved totally through voluntarism or even by the fortunately growing number of good extended benefit plans that exist within the private sector.

It also is true that as you grapple with what the public sector should do, it seems there is no avoiding the fact that the private sector employers must also do their share. We can afford some dollars for health insurance for the unemployed, more than we can afford greater numbers of uncared-for persons. There is no way either the government or employers can avoid costs. There is no zero cost option available on this issue. Failure to act to help specific groups in need is nothing less than fueling the fire and bringing national health insurance back to the forefront of the political agenda.

There is no way the Congress is going to devise a bill on this issue which resolves every concern for equity, every concern for every problem for every type of uncovered person in the Nation. That is not what is before you and therefore the failure to do so should not be considered a failure of either this committee, the Congress, or this legislation.

We believe strongly that there are several criteria that must fit any bill that you would consider, limit coverage to those whose loss of insurance is due to the loss of employment. Requirements both in H.R. 3021 and the Rangel approach on employers appear reasonable. The 90-day extended benefit requirement, spousal access option, and requirement for a conversion plan are within what we would consider the category of reasonable requirements for the Nation's employers to undergo. We do not believe this should be tied to the tax cap. We would say that regardless of whether or not we supported the tax cap. They are separate issues, to be addressed separately.

We hope that you will not come up with any kind of a design for new categories of requirements for employers that become disincentives either to basic health insurance itself or to the growing trend of extended employer benefits for those laid off. Do not include any new groups as an employer requirement such as unemployed parents, a proposal that exists in one of the Senate bills right now. Do not make medicare a new national minimum benefit package. Not only is it not well designed for the elderly that it seeks to serve today, not only is it a personally bankrupt program, but it is clearly not one designed to be a crisis program for people who are on and off unemployment rolls.

We believe the block grant approach is perfectly acceptable and is certainly preferable to an entitlement program that would stand to be vetoed. One of the virtues of the block grant approach is that the States can have further flexibility in the extent of benefits they provide without the Federal Government fearing an increase in the amount they are going to allocate in total.

Several times during this morning's discussion questions were raised about the extent of corporations that are under the tax cap or above it or who will be affected by this particular kind of program were it tied to the tax cap. I would caution you that there are no finite numbers to resolve that in a statistically exact way. Our looking at the very large employers suggests that approximately 50 percent today are at or close to the tax cap level of $2,100. What is significant there is that the vast majority of that 50 percent are very close to it, not way above it.

It would be some 6 years approximately from now before you had a significant majority of the largest employers, let alone the others, who were significantly above the tax cut. That we believe should be taken into consideration as you assess the value of that approach. Questions have been raised about the ability of the Government to manage the costs of such a program. There are ways, one can decide to approve contracts for specific categories of providers, to provide incentives for care through cost effective providers, to complete the minimum benefit design, narrow eligibility and have responsibile amounts of cost sharing. All those work positively from a cost-management perspective.

We would be very concerned that the Rangel approach changes the focus from those who lost insurance due to loss of employment, to those who have no financial ability to obtain private or other public coverage. Certainly issues of paramount importance to the Congress and the Nation as it considers health policy in the future, but not at the heart of the issue which we are here today to discuss. We believe very strongly that you must recognize the significance of the minimum package approach. Far better to do that, however harsh that may seem than to have the pretext of a comprehensive plan that the Nation cannot afford and ultimately will have to retreat from with apology.

The allocation formulas in the Rangel approach appear to be reasonable from a percentage standpoint but they call into question the disadvantage of using statewide unemployment levels. They are unable to account for subareas of a State where pockets of unemployment will be more than adequate to warrant intervention, but where the totality of the State's unemployment level would not call for intervention.

The sunset provision seems to be appropriate. Assistance for public hospitals is most supportable. It is certainly understandable as Mr. Stockman mentioned this morning that the essence of this effort is to address the needs of the individual who is suffering from the economic problems. However, that is not an available recourse on a one-by-one basis around the country. There is no denying the problem facing the public general hospital. It must also be noted that the more the public general hospital suffers through this problem, the more all others who are normally served by public hospitals also suffer regardless of whether or not they would be in line for any assistance from this particular program itself due to unemployment status.

So helping the public general hospital goes way beyond helping only those who are suffering their loss of insurance due to loss of insurance. It should be recognized as such.

Let me conclude by saying there is neither any cheap or easy way out of this problem. It is a systemic problem relating to structural unemployment far more than it is to any short-term unemployment. There is no way one can turn only to the private sector or seek redress only through a single governmental program. The appropriate way to address this problem is to create a partnership of new responsibilities in both the public and private sectors with a greater sense of how it manages the system for the benefit of those who really need the assistance.

Thank you.

Chairman FORD. Thank you.

[The prepared statement follows:]

STATEMENT OF THE WASHINGTON BUSINESS GROUP ON HEALTH BY WILLIS B. GOLDBECK

My name is Willis B. Goldbeck, President, Washington Business Group on Health. We are here today because the problem you are seeking solutions to is real; there is a legitimate role for federal government involvement; and many of America's leading employers recognize that they, too, must contribute to the solution.

As you would expect, our membership normally seeks neither an expansion of government nor mandated increases in the benefits provided to employees and their families. However, we do acknowledge that unemployment, with the resulting loss of medical insurance benefits, is a problem of national dimensions. As such, the responsibility must be apportioned among the various sectors of our society: Government must do its share to reduce any significant health crisis; the individuals involved will have to make painful personal resource allocation decisions thus sharing the financing of any proposed remedy; charity on the part of medical care providers and special community action programs are both necessary and, happily, becoming more prevalent. Finally, management and labor must do their share, not only as taxpayers but also by the direct provision of benefits extended for a reasonable period to those who lose their jobs through no fault of their own.

We reached these conclusions based upon analysis that determined:

1. No single sector of society can afford to assume responsibility for a total solution, thus a joint effort will be essential.

2. This is a problem which has no one to blame, only victims to help.

3. Society in general and the economic recovery particular will not be served by either ignoring the problem or by driving millions of former workers—and taxpayers—into poverty to obtain eligibility for existing public programs.

4. The problem is not a reflection of temporary economic doldrums but rather of the changing nature of work in America. Therefore, unlike past occasions when the issue has arisen, this time a national response is appropriate.

Attached as an appendix is a brief review of Trends In Extended Benefits which was initially presented in our January 24 testimony to the House Energy and Commerce Committee. Senators Dole, Riegle, Quayle and Representatives Waxman and Walgren all deserve credit for forcing this issue onto the public agenda and offering important proposals. We are pleased to see the Administration recognize the validity of this problem, however, we do not support making any new program dependent upon the proposed tax cap.

In reviewing these proposals, we tried first to clairfy the goal, establish some basic principles and then assess which elements of the proposals would be most successful in meeting these criteria.

Goal: To provide temporary, crisis-oriented, assistance to those who have lost, or in the future may lose, medical insurance as a result of unemployment.

Principles:

1. To establish a system of joint public, private, and personal efforts to address the current problem and similar instances that may arise in the future.

2. This unique program should not be a surrogate for national health insurance nor should it attempt to address all the other problems in health care financing and delivery.

3. There should be no pretence that this special program can provide replacement insurance protection. A new minimum benefit package should be offered.

4. That benefit package should have some emphasis upon prevention.

5. Federal financing should be seen as a catalyst for state and private sector program development.

6. States should be given maximum flexibility in program design and financing.

7. Financial assistance should be targeted to those hospitals which are providing an increasing amount of uncompensated care due to the unwillingness of other hospitals to accept those who have lost insurance due to unemployment.

8. Requirements on employers should:

A. Not be a disincentive for the growing number of voluntary and negotiated extended benefits.

B. not impose such a burden that the provisions of basic medical insurance will be reduced (small employers) or that unemployment will be increased (large employers already in major economic difficulties.)

C. recognize that many families now have two wage earners both of whom have access to private insurance benefits.

D. not result in financing pools and programs in which the unemployed receive greater benefits then they had while working (which would be the case if Medicare or many Medicaid programs became the "minimum" benefit.)

Our members responded to a survey that sought their views on each legislative proposal. A review of the completed responses shows:

1. Agreement to provide an immediate access period to a spouse who has lost his/her own job. Please be aware that for some companies, especially in retail, this will be a very costly and complex requirement. Congress may feel it is appropriate to provide such firms with an extended starting time.

2. Agreement that all employment-based medical insurance shoud include a conversion opportunity.

3. Acceptance of the 90-day benefit extension requirement as representative of a moderate approach which, while far from inexpensive for employers, is consistent with the trends in voluntary benefit extension.

4. Opposition to nationally mandated pools. If these were experience rated, like unemployment compensation, then the companies with the worst economic conditions would have to pay for the whole pool. Alternatively, if the pool is not experience rated, then those firms which never have lay-offs would be paying millions for a benefit that their workforce never receives.

5. Support for the minimum benefit approach in the Waxman bill. The importance of this proposal should not be overlooked. It is a bold statement which recognizes that the federal government has an appropriate role in crisis reduction but, that role does not necessarily extend to maintenance of the status quo or to providing a guarantee of cost-free care for every real or perceived need. Medicare is not supported as a minimum benefit.

6. Concerns that Congress not provide an unnecessary incentive for inpatient utilization, such as denying coverage of drugs for chronic care paitents unless they are hospitalized.

7. Support for the prevention orientation of the maternal and child care proposal coverages.

8. Support for state program flexibility and the provisions in H.R. 3021 that would allow employer requirements to vary by state within proscribed minimums.

9. Opposition to the concept of making employer plans responsible for unemployed parents of workers unless the parent is a dependent under the terms of the applicable IRS codes and existing employee benefits agreements.

10. H.R. 3026 Part B, Section 2111, open enrollment, continuation and conversion rights. The term "involuntary lay off or separation" is not fully understood. It would appear to limit eligibility to those who left work involuntarily. This is the interpretation we support. However, employees who quit voluntarily are, in many states, eligible for unemployment compensation. If the health program is tied to UC then won't those who quit, as well as those who go due to "involuntary lay off or separation" be eligible? This needs clarification not only for employers' planning and employees' expectations, but also for your own budget projection.

11. We do not support proposals that create a dependency between the provision of health insurance for the unemployed and passage of a tax cap on employee health insurance benefits.

CONCLUSION

There can be no denying that the simultaneous loss of employment and health/medical insurance protection can be devastating. This is not an issue on which the employer community is likely to speak with one voice . . . which is quite appropriate since the impact of proposed legislation would vary dramatically depending upon a wide range of factors, many outside the control of individual employers.

Some companies simply do not accept the philosophy that government (and mandated private sector programs) should intervene in the economic ups and downs that represent a fluid, primarily free market, economy. Concerns are raised that special benefits become just one more disincentive to accept new employment opportunities, especially those with weak benefits. Others note the seeming incongurity of rushing to create special legislation to help those who have just lost their jobs when programs for those who are already destitute are being reduced.

All employers realize that the price of any new plan will be high. Utilization is high for those who are unemployed thus resulting in not only expenditures for actual claims but also in upward pressure on the premiums for experience rated firms.

Despite all these very real concerns, it is our belief that a carefully designed, modest program warrants support. There will be added costs for our members, but they also know that there is an unavoidable price of unemployment as costs for uncompensated care are shifted to private payers. The unemployed need help and we are prepared to do our share.

APPENDIX.—TRENDS IN EXTENDED BENEFITS

Years of service	Extension of benefits				
	End of month	End of month plus	6 months	1 yr	2 yrs
Less than 1 yr	X	X	X		
Less than 2 yrs	X	X	X		
2 to 10 yrs			X	X	X
More than 10 yrs			X	X	X

This chart captures the primary categories of extended benefits in relation to duration of service. Many companies have no benefit extension; others have a set amount regardless of service and there are countless variations that defy placement on any chart that would remain comprehensible.

Utilization

Not surprisingly, our companies report increased utilization of medical benefits during periods of layoff. And this does not count the increase in diseases and accidents that are directly attributed to unemployment itself. Elective surgery is a major area of increase.

Insurance

Nationwide is marketing a hospital/surgical benefit in 60 or 120 day policies specifically aimed at the recently unemployed. While not inexpensive, they are considerably less than a regular, non-group policy which, with a $250 deductible, would be approximately $1900 per year. For a typical 30 year old couple, the unemployed plans would cost (60-day) $56.60 (120 days) $113.00. Coverage is limited but would be a major asset in any medical crisis.

Employee contribution

Many companies require laid-off workers to make some financial contribution to the insurance premium. There is a great variation in this practice with duration of service, duration of layoff, and number of dependents among the determining factors.

Coverage comparability

Some employers reduce the coverage for those on extended benefits. Again, the patterns are not conclusive. While some emphasize protection from catastrophic expenditures, others drop the major medical although continuing the basic hospital and surgical benefits. The trend is to keep the full coverage and drop dental.

"Lost" benefit

The total number of persons laid off in recent years contains many who had been employed for so short a time they had never passed through the waiting period. Thus, they had no benefit to lose. Another category had benefits but not enough seniority to earn any benefit extension. Then there are all those who had benefits and varying degrees of extensions. All of which further shows the dangers of thinking of the unemployed as a single group with comparable circumstances.

Self-pay options

Several companies reported that they offer those laid off the opportunity to by into the full group plan coverage. Acceptance runs from 12–33% of those eligible thus many must conclude that the price is too high, either in absolute terms or in relation to other demands on their shrinking resources.

Note.—This information reflects the experience of a select group of very large firms. It is not typical of all businesses.

Some typical examples are:

Company and service	Benefit extension
Tenneco:	
Salaried;	
Less 6 mo	1 mo.
6 to 12 mo	6 mo.
1 yr	1 yr.
Hourly:	
Less than 4 yr	6 mo.
More than 5 yr	1 yr.
Libbey-Owens-Ford, glass division	6 mo.
Motorola	1 yr.
Alcoa:	
Less than 2 yr	26 weeks.
2 to 20 yr	2 yr.
More than 20 yr	Full retirement level.
Kodak	End of month plus 2 mo.
American Can:	
Less than 10 yr	6 mo.
More than 10 yr	23 mo.
Kroger	End of month plus 2 mo.
Bethlehem Steel:	
2 to 10 yr	6 mo.
More than 10 yr	1 yr.
Boeing	60 to 90 days.
Ford:	
Less than 10 yr	1 yr.
More than 10 yr	2 yr.
Goodyear:	
Salaried:	
Less than 1 yr	3 mo.
1 to 2 yr	6 mo.
More than 2 yr	2 yr.
Hourly:	
Less than 2 yr	3 mo.
More than 2 yr	2 yr.
Westinghouse: 3 yr	1 yr.
Armco:	
Less than 2 yr	1 mo.
2 to 10 yr	6 mo.
More than 10 yr	1 yr.
Kimberly-Clark	1 yr.

CHANGING NATURE OF WORK IN AMERICA

On the surface, it sounds so reasonable and so simple: provide emergency legislation to give health insurance coverage to those who lose coverage due to loss of employment. Below the surface lies a morass of rapidly changing demographics, emerging shifts in how we value work, trends in technology and education which are out of balance with the needs and skills of our workforce, and the harsh reality that there are good reasons for what we have come to call structural unemployment.

Like it or not, the nation is not facing a short term unemployment problem that is suited to emergency approaches. To further complicate matters, the overall matrix of economic problems, including the deficit, are forcing reduced funding to public health, Medicare and Medicaid. Thus the ethical dilema: do we create a new category of persons eligible for assistance at the very time we are cutting back for those already in dire need.

How we are changing: Who we are

The American worker is increasingly female or foreign, or both, and is getting old. While our total fertility rate has stayed below replacement level since 1976, im-

migration and longevity have been the keys to population growth. For every 4 persons who entered the labor force in the 1970s, only 3 will do so in the 1980s. One result of an aging workforce is a reduced pool of those able or willing to take low skill, night shift, or hazardous jobs. Another complication is the incompatibility of a youth-oriented education system when it is the adult worker who needs education and training to be of value in tomorrow's job markets.

Between 1969-79 we consumed, but surely did not assimilate, 4.3 million immigrants. Our "melting pot" was swamped by a 815% increase in Asian immigration while the inflow from Europe decreased by 46%. Mexican immigration alone went up 92.8%. It is not just the nature of work but also the worker who is changing.

In the process of these and other changes, the family unit of a working father and a mother as homemaker has been transformed from a classic to myth. Work in previous generations was unavoidable if one was to survive and the structure of work fit the family structure. Today, we see both structures in the midst of change.

How we are changing: The value of work

We were trained to consume, to live for the next generation, to work in order to eat, to produce in order to win. Although from different political isms, Karl Marx and Adam Smith were allies in fostering work ethics that are increasingly meaningless for post-industrial societies. As a nation, there is no longer a necessary relationship between productive capacity and full employment. We may need full employment for many other reasons, but not to produce the goods and services for either survival or growth.

The structure of work is changing to meet this new reality. Job-splitting, flexitime, permanent part-timers, compressed work weeks, and cafeteria plans are all related to the new prevalence of dual-earner families, few children, and strikingly different values being attached to work itself.

The shift from a manufacturing society to a post-industrial information society has been accompanied by other shifts: from replacement demand to maintenance demand; from an emphasis on quantity to one on quality; from fear-based incentives to self-realization and participatory management; and from the consumption ethic to one of ecological conservation.

We have chronic un, and under, employment in part because we have so overinflated the criteria for jobs that many who are indeed capable are not eligible. From all of this, we have a growing number of those whom Willis Harmon has called "the superfluous people", those not fortunate enough to be employed while existing in a society where the fact of employment is still deemed a prime indicator of successful participation and contribution to that society.

How we are changing: New values, new behavior

Waiting for our traditional industries to "recover" is no less a fantasy than waiting for ET to phone home. We're already in Naisbitt's "information society", Lumford's "bio-technic culture", and Robert Hutchins' "learning society". All these and many more are delivering the same message.

Public behavior is already reflecting these changes. Leisure time has never been more highly valued. Appropriate technology with its emphasis on decentralized production and doing more with less is in sync with America's new migration to unincorporated rural areas. The high tech of telecommunications is helping the entrepreneurial spirit converge with the "small is beautiful" value orientation.

Let me give an example to demonstrate the impact of the changing nature of work as contrasted with the traditional view of layoffs.

The following chart describes the workforce of a southeastern manufacturer which offers hourly workers with 3-10 years of service a one year extension; two years if beyond ten years of service.

HOURLY WORKERS

Year	Total	On layoff
1980 (January)	22,122	642
1981	20,466	1,598
1982	16,165	4,682
1983	14,353	3,662

From this chart you can see a reduction of 7,769 yet only 3,662 now on layoff. The difference (4,107) represents those already "structurally" unemployed and thus beyond the responsibility of their former employer.

Another example shows the growing severity of the problem. A midwest heavy equipment firm currently has 12,522 on layoff. They average 226 days on layoff. Of the total 10,378 still have employer provided extended health insurance coverage. However, 10,155 will lose that in 1983.

Whether from the management or union perspective, one must ask if it would be good policy for the government to require firms, some of which have reasonable health care coverage, to expend even more funds for extended benefits. New financial obligations can only result in more layoffs or reduced compensation for those who remain employed.

Note.—Data compiled January 23, 1983.

Chairman **Ford**. Mr. McKevitt.

STATEMENT OF JAMES D. "MIKE" McKEVITT, DIRECTOR OF FEDERAL LEGISLATION, NATIONAL FEDERATION OF INDEPENDENT BUSINESS

Mr. **McKevitt**. Thank you, Mr. Chairman. I know you and Mr. Moore would like to close shortly. I would submit my statement for the record and make a brief oral statement.

I would like to point out we now have 575,000 members across the country. I appear here on their behalf today as Director of Federal Legislation.

I would like to point out, Mr. Chairman, that with the recent enactment of TEFRA, the social security amendments, this has placed two new additional payroll burdens on employers and has had a big impact on small business exmployers. We are primarily labor intensive rather than capital intensive. Now, to face another burden such as increased health care costs would be—would have an alarming effect.

I think of the example of ERISA when everybody thought you were voting for motherhood and thought it would be a good plan. I would venture to guess probably half our members who had retirement programs dropped them as a result of ERISA. I would venture to guess that of the 57 percent of our members who have health coverage now for their employees there is a goodly number that would probably drop their health plans too by saying I just can't afford this additional burden.

We have got the FICA and FUCA, for example, you look at 35 increases from 1970 to 1990 already on the books, payroll taxes just keep going up and up. Now we look, for example, at the spiraling inflationary impact of health care costs. You look at medicare as it begins to reveal itself and the burdens it will bring to the payroll, and to look at this, it would be devastating to the businesses of the country, particularly labor intensive businesses.

I know it would for the small businesses which I represent here today. So I would hope this committee, therefore, if it does focus on solutions would bear in mind also those 20 States like Pennsylvania where I was last week meeting with various officials of State government. They are wrestling with how they are going to, what taxes they will raise to wipe out the deficits on their unemployment compensation problem because it is a large one as Illinois and other States are, too. It places another—into the program of unemployment compensation for State programs I think would be a tremendous burden for the employers and also the States, too.

I would hope you would look at things like maybe catastrophic coverage as an alternative, alternatives of the private sector rather than a broad-based health care program because I think it is something the system cannot stand economically right now.

Thank you.

Chairman FORD. Thank you.

[The prepared statement follows:]

Statement of James D. "Mike" McKevitt, Director of Federal Legislation, National Federation of Independent Business

Mr. Chairman: My name is James D. "Mike" McKevitt, Director of Federal Legislation for the National Federation of Independent Business (NFIB), and I thank you for the opportunity to comment on the subject of health insurance for the unemployed.

In the last year, employers, especially labor-intensive small business employers, have witnessed dramatic increases in the costs to maintain an employee. The first shock occurred in the Tax Equity and Fiscal Responsibility Act of 1983 (TEFRA), which mandated substantial increases in Federal Unemployment Tax (FUTA) contributions along with similar increases at the state level. These taxes were raised in response to high unemployment and the fact that the unemployment compensation programs in more than a dozen states were on the verge of bankruptcy. The second shock occurred with the recently passed social security reform legislation, which mandates massive FICA tax increases beginning next year and increasing through the decade.

Small firms are especially sensitive to these variety of tax increases because they are labor intensive, and labor costs have become so high a percent of their operating expenses. Prior to the current recession, small business was responsible for more than half of all new jobs created. However, another trend shows that the base of taxation for a majority of small firms has become labor, not income. In 1980, a study of tax burdens for five typical small businesses revealed that over 70% of their tax burdens were a result of labor-based taxes.

Legislation to promote health insurance benefits for the unemployed is now being considered. Today more than 20 state unemployment compensation programs are in deficit situations. This legislation proposes to place further burdens on the state unemployment systems, which must eventually be translated into greater unemployment compensation taxes. In addition, employers will be forced to incur substantial new costs for medical insurance for laid off employees or laid off spouses.

Labor is a major factor in the productivity of small firms. Layoffs only occur when the business has no prospect of increasing sales. The recent recession provides ample evidence of the impact of reduced sales on small business employment. However, in the most recently published Quarterly Economic Report, despite solid increases in the sales and earnings of the membership, employment did not rise. Although one can speculate on the reasons for this lack of increase in employment, increased costs of labor and greater FICA and FUTA taxes—which firms must pay whether profitable or not—has been an inhibiting factor in small business employment.

The part of the program which is of greatest concern to NFIB is the imposition of increased costs on employers for health insurance both when employees are discharged or when spouses who may be discharged. The program mandates new costs for employers and does not take into account alternatives to the loss of employer-sponsored health insurance, such as individual continuation of an insurance plan or the purchase of less expensive catastrophic insurance coverage.

In a survey taken of NFIB's membership in 1978, 57 percent of those surveyed provided health insurance coverage. For those firms with sales over $800,000, it was almost 90 percent. It is this group that most likely would have 25 or more employees. The same survey asked what the employer's response would be to federally mandated minimum benefits of health insurance coverage, and almost 50 percent of the same group stated they would drop existing coverage.

It is quite clear to us that small business will react negatively to mandated health insurance coverage. NFIB opposed such coverage in a membership vote by 3 to 1. It is also quite clear that many unemployed individuals can face a cutoff of health insurance coverage at a time when health care costs are running rampant and a short illness might devastate a family's assets. However, there has been little discussion of alternative solutions, or even of defining the specific populations most affected and determining their alternatives for medical insurance.

The major portion of the program establishes a state health insurance pool for the unemployed, partially funded through employees' u.c. benefits and federal and state revenues. While we would not oppose this concept, we are opposed to increased cost burdens being placed on the state and federal unemployment compensation system. Quite possibly, the coverage being requested by Congress is too expensive and extensive. If coverage is too good, employees will drop private plans, which is clearly not the intent of this proposal. A lower cost, more limited catastrophic coverage would be preferred, so that employees contributions would be sufficient to pay the cost.

In conclusion, we are very concerned over potential increases in employer labor costs due to mandatory health insurance coverage for unemployed individuals. We would encourage this committee to move slowly in this area and not to establish a program in which beneficiaries are assisted, thereby hurting its intended beneficiaries. At the same time, it is important to explore alternative solutions to this problem and to clearly define who is to be assisted. Health care cost increases are the major inflationary factor in the economy, and Congress must be mindful of not establishing new government health care programs which further exaggerate that trend. Private sector alternatives are attractive because we are very concerned that proposed insurance costs not be so great that state unemployment systems must incur heavy new expenses and place further strains on already overburdened state budgets and unemployment compensation systems. Thank you, Mr. Chairman.

STATEMENT OF JAN PETER OZGA, DIRECTOR OF HEALTH CARE, CHAMBER OF COMMERCE OF THE UNITED STATES, ACCOMPANIED BY MICHAEL ROMIG, DIRECTOR OF EMPLOYEE BENEFITS

Mr. Ozga. Thank you. I am Jan Ozga, with the U.S. Chamber. We are concerned about the plight of those Americans who are in the double jeopardy of being without a job and without health insurance. We are equally concerned about the rush to pass legislation that is in our view not necessary and aggravate the problem. Accordingly, we oppose the two bills and the recently advanced proposal of Congressman Rangel.

Among our reasons for opposition is that we still have not determined how large the problem is. The Bureau of Labor Statistics revealed that of the 11 million unemployed, less than 2 million are layoffs and less than 5 million are job losers. What we don't know is how many of these people have availed themselves of the existing public and private options to obtain protection for health care costs. These include continuing coverage of up to 3 months which covers about two-thirds of those now unemployed, and allowing employees to be covered by converting their group policy into an individual plan.

In nearly 60 percent of the States these continuous coverage features are required by law. Forcing employers to add such features could cause them to reduce other benefits, drop health insurance benefits altogether or layoff more workers.

It should be noted that many unemployed come from households in which another employed member is insured. So this loss of a job does not necessarily mean loss of access to health benefits. Many employers allow immediate signup to employees who did not seek their plan but do so when their spouse's employment is lost. Thus this obviates the need for mandated open season as some of the bills require.

We must also not overlook the assistance provided through State and local health clinics, aid from family and friends, fraternal and civic groups, and the generosity of the hospitals and physician community which have been rendering low cost, in some cases even free care to those in need. For the truly needy, we must not overlook medicaid.

The States have been identified as appropriate administrators of a program for health insurance for the unemployed. If the State used existing block grant moneys or deductions from unemployment compensation to finance such a program, we would find it acceptable, although witnesses who would implement these programs have testified today that there are severe problems in the administration and financing of these programs at the State level.

But we noticed the proposals also talk about new Federal money. We are particularly opposed to financing such a program with a tax on health benefits on American workers as the administration has proposed through the so-called tax cut.

In our written statement we highlight the problems associated with ERISA and unemployment compensation. For example, we find it rather ironic that the Congress which last year chose to tax unemployment compensation benefits—presumably because some claimants were overpaid—now seeks to aid these tax beneficiaries with federally subsidized health insurance.

In summary, the chamber opposes legislation to provide health insurance to the unemployed as proposed because such proposals will add to Federal deficits and employer costs and are not necessary, given numerous options available through private and public programs. Full employment is the quickest and surest way to cure the problem of loss of health insurance through loss of employment. Our energies are best devoted to this objective.

In the meantime other health insurance options should be exercised, so the need for Federal intervention is not necessary.

Thank you.

Chairman FORD. Thank you.

[The prepared statement follows:]

STATEMENT OF JAN PETER OZGA, DIRECTOR OF HEALTH CARE, CHAMBER OF COMMERCE OF THE UNITED STATES

My name is Jan Peter Ozga. I am Director of Health Care for the Chamber of Commerce of the United States. Accompanying me today is Michael J. Romig, the Chamber's manager of Human Resources and Employee Benefits.

The U.S. Chamber is deeply concerned about the proposals to provide health insurance for the unemployed and the cost of such legislation to employers, employees and taxpayers. We believe state and local programs and voluntary action are appropriate and effective responses and stress our complete opposition to financing any such program through the enactment of a tax on health insurance premiums.

Accordingly, we opose H.R. 3021, H.R. 1823 and other legislation that would create new entitlement programs and increase employer costs.

DEFINING THE PROBLEM

Most Americans obtain health insurance through their employment. Indeed, the most recent figures from the U.S. Department of Labor reveal that 75 percent of the workforce is covered by group health insurance (see Table 1 in Appendix). This coverage ranges by size of firm and union status (Table 2), by industry (Table 3), and by geographic area (Table 4). Another factor in coverage is length of service with an employer. Most firms require anywhere from one to six months probationary period before coverage becomes effective.

Although these data confirm that employment is an important element of health insurance coverage, they do not confirm, as some suggest, that unemployment translates into lack of health insurance *per se*. In fact, only a relatively small percentage of the unemployed ever face the prospect of high health care expenses without access to health insurance. Here is why we believe that the problem is not a major one.

First, many employers provide very extensive health insurance coverage for their employees on layoff. Perhaps the best example of this is the coal mining companies that offer as much as one year of continued protection. For most employers, the continued coverage ranges from one to three months, which effectively provides complete protection for about two-thirds of the unemployed (Table 5).

Second, nearly every state insurance code requires employers to offer continued enrollment, at employee expense, to all employees who leave the job. Some employees exercise this option.

Third, many of the unemployed come from households in which some other member is the source of group health insurance. For example, one-half of unemployed married men have a working wife and three-quarters of unemployed married women have a working husband. Overall, two-thirds of those families with someone unemployed have someone else working.

Fourth, the unemployed may purchase health insurance policies, the cost of which varies depending on comprehensiveness. In addition, medical expense coverage for accidents is available in various other forms of individual insurance, such as auto and homeowners. And, for those aged 65 and over, Medicare is readily available.

Finally, for the unemployed who have no health insurance, there may be help from other family members, friends or charitable organizations, and from the many physicians and hospitals who respond to urgent needs with reduced cost or free services. And, in some cases, there is the social safety net, i.e., Medicaid, which is available to the truly needy.

So far, no one has quantified the unemployed who actually are without health insurance. Without such numbers, we are left with very expensive solutions to a problem that may require a much less expansive solution. For example, of the 11.2 million unemployed: 3.7 million are new entrants or reentrants to the labor market; 8 million quit their jobs; 1.9 million are on layoff; and 4.8 million are job losers. The job losers and those on layoff are the key groups. But, we dob not know how many of these people have health insurance because of the various options described above.

COSTLY ENTITLEMENTS

Faced with this dilemma, Congress is being asked to consider fashioning new entitlement programs, issuing federal mandates on employer group health plans, or a combination of these approaches.

These committees are considering H.R. 3021, the Waxman-Madigan bill that was recently approved by the House Energy and Commerce Committee. H.R. 3021 requires employers of 25 or more people to (1) provide a 30 day open enrollment period to allow employees to secure coverage for their unemployed spouses (2) carry unemployed workers for up to 90 days after being laid off. A joint federal/state program would go into effect after this 90 day period.

The potential for an exceedingly expensive program exists in each proposal because of the inherently difficult political choices associated with designing such programs. For example, who would be served, the unemployed and dependents? Is there to be a means test?

A second difficult choice would be over how much health insurance is to be provided. If it is too dangerous, will people drop present coverage to obtain it? If it is catastrophic only, what level is fair to both taxpayers and those who would be covered?

Then, there are the difficult questions raised by those proposals that would require employers to expand their group health benefit plans. Early estimates predict that this could add $2 to $6 billion to annual health care benefit costs. If H.R. 1823, requiring one year of continued coverage, is enacted, how are financially troubled firms to survive? After all, these firms were forced into layoffs because they could no longer afford to employ some of their workers. How are they to pay for health insurance? By laying off more workers?

And what about small firms that have been able to provide only minimum health benefits for their employees? Would not the cost of mandated programs cause them to drop that coverage or reduce it further?

ERISA IMPACT

Finally, another concern to which little, if any, attention has been directed, is the uniform federal regulation of employee benefits embodied in the Employee Retirement Income and Security Act (ERISA). Legislation before these committees would authorize the States to enact legislation mandating inclusion of certain health benefits for the unemployed within their group health plans. If enacted, this would violate the intent of Congress when it enacted ERISA in 1974, and every amendment to that Act, to preempt state regulation of employee benefits. In fact, all the legislative proposals we have examined so far on this issue have ignored the fact that Congress has chosen ERISA to be its primary statute for regulating not only pensions but all employee benefits, including group health benefits.

GROWING LABOR COSTS

We are also concerned by the prospect of one more federally mandated labor cost. The labor wedge in the United States, i.e., the cost of employing a worker over and above the wages that a worker and employer might agree upon, has undermined our nation's productivity and international competitive position. Much of this is traceable to federally mandated labor costs.

For example, additional increases in labor costs will continue to make labor relatively more expensive than plant and equipment. As a result, there will be a tendency for employers to substitute labor saving equipment for labor.

Recent examples of government-mandated increases in labor costs include higher payroll taxes for Unemployment Compensation and Social Security, higher pension and health care costs as a result of TEFRA and numerous state government mandated increases. Unemployment increases resulting from higher labor costs depend on how sensitive the demand for labor is to changes in the price of labor. These facts do not seem to have been adequately considered by proponents of legislation to mandate increased labor costs on employers.

EFFECT ON UNEMPLOYMENT COMPENSATION PROGRAM

Any new government-subsidized health insurance plan for the unemployed will create problems for the unemployment compensation (UC) program.

UC is no poverty program—some claimants have substantial assets. For example, 1979 income tax records reflect more than a million and a half tax returns reporting adjusted gross income of $20,000 or higher and also receipt of unemployment compensation. Moreover, when unemployment benefits are combined with other income support programs, some claimants actually come out better than when they were working. Given the existing federal budget deficit, government-subsidized or free health insurance coverage is hard to justify for a substantial number of claimants. Those unemployed individuals receiving UC have a source of income and may be the least in need of more government care.

Advocates of government health insurance for the unemployed argue that UC benefits are too little to buy health insurance. Ironically, last year Congress sharply raised the income tax on UC—vocifer over our vociferous objection—evidently in the belief that benefits were too high! Without that tax, claimants would certainly be better able to obtain insurance on their own.

Another reason that receipt of UC benefits is not a reasonble criterion for health insurance eligibility is that UC entitlement depends on a weekly job search. Benefits are paid provisionally, subject to confirmation of qualification. Disqualification for UC benefits may or may not be relevent to eligibility for health insurance.

Moreover, the new benefits would weaken the incentive for UC claimants to accept part-time and temporary jobs when permanent jobs are unavailable. At present claimants resist such jobs because earnings from 2 or 3 days of work disqualify them from benefits. If claimants will lose health insurance for weeks in which they are disqualified from benefits, they will have even less incentive to accept available work.

Finally, any new responsibilities assigned to the state UC administrative agencies would further hinder their ability to carry out their basic—but often forgotten—mission: finding new jobs for the unemployed.

TAX CAP FINANCING

OMB Director David Stockman has suggested using a tax cap to finance a program of health insurance of the jobless. We totally oppose this proposal. Our opposition to a tax on health insurance is premised on several considerations:

A tax cap simply will not generate the expected revenues since "excess" health benefits will be shifted to other forms of non-taxable compensation. We would then be left with one more unfunded entitlement program.

A tax cap would be a poorly disguised tax increase at a time when the need for economic recovery calls for less taxation.

A tax cap would be unfair to female, older, and handicapped workers and workers who live in high health cost areas. Developing a cap that varies by sex, age or geographic region might be more equitable, but it would be an administrative nightmare and would lead to more bureaucracy and regulation.

A tax cap would be difficult for employers who self-insure because they would have to calculate the equivalent of a premium. But once identified, this "premium" cost would be the target for state taxation, from which it is currently exempt.

A tax cap would increase health care cost by thwarting competition. Cost-effective alternative delivery systems, such as health maintenance organizations (HMOs), would be less attractive, because their premiums tend to be higher than those of traditional health insurance and thus subject to tax.

In sum, taxing health insurance is an idea we vigorously urge you to abandon.

RECOMMENDATIONS

The U.S. Chamber recommends against enactment of a new special entitlement program to provide health insurance benefits to unemployed workers. Present arrangements consisting of a combination of employer provided coverages, individually purchased coverages, Medicaid/Medicare and free medical services are largely meeting the need. Current proposals would increase state financial burdens associated with Medicaid and unemployment compensation.

The economic recovery has started and the full benefits of such recovery are imminent. The higher level of employment that lies ahead in the next several years is the best solution to the health insurance coverage problems of those currently unemployed. Adding costs to employers will impede progress toward recovery.

These options are clearly preferable to federal intervention that could evolve into open ended entitlement programs, increased federal deficits, impeded recovery and the addition of unmanageable burdens on small business.

TABLE 1.—DISTRIBUTION OF FULL-TIME WAGE AND SALARY WORKERS BY GROUP HEALTH INSURANCE STATUS AND TYPE OF EMPLOYMENT

Type of employment	Percent distribution by coverage status			
	Total	Covered	Not covered	Do not know
Total	100	75	23	2
Private	100	73	25	2
Government:				
Federal	100	83	16	1
State	100	88	11	1
Local	100	81	18	1

TABLE 2.—COVERAGE OF FULL-TIME WAGE AND SALARY WORKERS IN PRIVATE INDUSTRY, BY SIZE OF FIRM AND UNION STATUS

Size of firm and union status	Percent distribution by coverage status			
	Total	Covered	Not covered	Do not know
Total	100	73	25	2
Union contract	100	91	8	1
No union contract	100	67	31	2
Under 100 persons	100	62	37	1
Union contract	100	87	12	1
No union contract	100	56	42	2
100 to 499 persons	100	87	12	1
Union contract	100	93	7	....
No union contract	100	84	15	1
500 or more persons	100	94	5	1
Union contract	100	96	3	1
No union cosntract	100	93	7	....

Source: "Health Benefits Lost Due to Unemployment," Committee on Finance, U.S. Senate, April 1983.

TABLE 3.—COVERAGE OF FULL-TIME WAGE AND SALARY WORKERS IN PRIVATE INDUSTRY, BY INDUSTRY

Industry	Percent distribution by coverage status			
	Total	Covered	Not covered	Do not know
Agriculture	100	31	63	6
Mining	100	85	13	2
Construction	100	59	36	5
Manufacturing (durable)	100	89	9	2
Manufacturing (nondurable)	100	84	14	2
Transportation	100	81	17	2
Communication/public utilities	100	92	6	2
Trade—wholesale	100	78	19	3
Trade—retail	100	58	39	3
Finance, insurance and real estate	100	76	22	2
Services	100	61	37	2

TABLE 4.—COVERAGE OF FULL-TIME WAGE AND SALARY WORKERS IN PRIVATE INDUSTRY, BY GEOGRAPHIC AREA

Geographic area	Percent distribution by coverage status			
	Total	Covered	Not covered	Do not know
New England	100	77	21	2
Middle Atlantic	100	77	20	3
East North Central	100	79	19	2
West North Central	100	70	28	2
South Atlantic	100	69	28	3
East South Central	100	70	28	2
West South Central	100	66	30	4
Mountain	100	67	30	3
Pacific	100	72	26	2

TABLE 5.—*Duration of layoff benefit protection for workers with benefits*

Length of layoff benefit protection:	*Percent*
All workers with layoff benefits	100
Less than 3 mos	19
3 to 4 mos	25
5 or more mos	28
Varies by length of employment	22
Data not available	2

Source: "Health Benefits Lost Due to Unemployment," Committee on Finance, U.S. Senate, April 1983.

Chairman FORD. Mr. Bliss.

STATEMENT OF DONALD T. BLISS, MEMBER, POLICY SUBCOMMITTEE ON HEALTH CARE, NATIONAL ASSOCIATION OF MANUFACTURERS, ACCOMPANIED BY SHARON CANNER, HEALTH CARE ANALYST

Mr. BLISS. I am Don Bliss, an attorney and member of the National Association of Manufacturers Health Subcommittee. With me today is Sharon Canner, a health care analyst at the NAM. We have submitted our full statement. I would like to summarize it for the benefit of the committee.

We appreciate and commend the committee for looking at what we agree is a serious national concern—health insurance for the unemployed. However, we believe the experience of the last few years teaches us that in addressing problems of health care financing, we must avoid the creation of new Federal entitlement programs, the establishment of new Federal or State bureaucracies and the addition of new financial burdens on the already overloaded Federal health care budget.

However well intended such programs may be, they too often come into play rather late in the process of the economic cycle upswing, when that swing is well underway and the recovery is going forward. The programs may have the unintended effect of fueling the flames of inflation or exacerbating the uncontrollable aspect of deficit. The effect may be to harm the economic recovery which will put people back to work—the objective we all feel is the real solution to this problem. Thus in today's economy we think the solution to this very serious problem must be found to the maximum extent possible in the private sector. For this reason we believe any Federal legislation should build on the existing private insurance structure, much as the private insurance elements of the bills before the committee, H.R. 3021 and Congressman Rangel's draft bill do.

We fully support those elements of the legislation and indeed would build on them in finding a private sector solution to the problem. We agree, for example, that existing job based group health plans should be extended for at least 90 days after layoff. This continuation of coverage should be a condition of the employer's deductibility for health benefits now provided under the Internal Revenue Code. We prefer that approach to tying this condition to the Fair Labor Standards Act.

The former workers' coverage would be maintained at the same benefit levels and cost-sharing arrangement that existed before layoff. In addition, we agree with the committee draft bill and H.R. 3021 that in the event an unemployed worker's spouse loses a job due to layoff, the employer of the working spouse should be required to offer insurance coverage immediately upon expiration of the 90 days. We note some 42 percent of the unemployed have working spouses so that this would take care of a substantial part of the problem.

Indeed we would build on these private sector solutions that are incorporated in the committee draft bill and in H.R. 3021. We would suggest that after the 90-day mandatory extension a second phase would take effect. Here the former worker would have two choices. He could continue the same coverage at the cost paid by the former workers, or alternatively purchase a low option basic insurance package that would reduce substantially the cost of coverage. The low option would include some hospital and physician services and perhaps catastrophic coverage.

Finally, we believe that to facilitate the reentry of workers to new jobs, health insurance coverage at the new place of employment should be made to become effective not later than the 31st day of employment. New employees currently have to wait 1 to 6 months for coverage. Special open enrollment restrictions would be eliminated under these circumstances. These four steps, in our view, constitute a private sector approach to a serious national problem. The principal benefit of this approach is its administrative simplicity and use of existing structures. Use of these private insurance structures to assist the laid off worker would not require a new Government agency or staff.

With respect to H.R. 3021 and the committee bill, we therefore support and generally agree with the private insurance provisions contained in those bills. In fact, we would build upon these and expand them. We do not believe the creation of a new Federal entitlement program would be wise public policy at this time. However, if this committee believes Government involvement is necessary beyond the existing programs in existence, we would certainly prefer the block grant approach over some of those proposed.

We believe the following principles, some of which are reflected in the bills before the committee, should underlie any such legislation. First there should be no new permanent Federal entitlement or agencies created. Second, the States should have maximum flexibility to administer the program according to local needs. Third, choice should be preserved, including the private insurance option. Fourth, the program should be limited to the temporarily unemployed and limited in time. Fifth, the program should not be tied to the administration's ill-advised proposal to put a cap on health insurance deductions for the employer.

We think this type of Robin Hood economics is totally inappropriate and based on faulty economic assumptions. The two issues should be considered entirely distinctly and separately. We think the committee rightfully should limit its deliberations here to the problem of health insurance for the unemployed. We hope that before any Federal program is recommended, however, that these subcommittees will give serious thought to the following concerns.

What will be the effect of spending Federal dollars on new health care programs at a time of escalating budget deficits and spiraling health care cost inflation? What are the realistic projections for spending in the outyears? Is it fair to cut back on entitlement programs for the elderly and poor who must rely on Government aid while at the same time creating new categories of eligible persons? Will the coverage be provided only to those who truly need it, recognizing that some unemployed persons have extended coverage up to 2 years after layoff, some have adequate resources to pay for insurance, some are eligible for medicare, medicaid, and other Government programs and others are beneficiaries of private voluntary programs?

If after reviewing all these concerns the subcommittee believes Federal revenues are needed, we believe the block grant would offer the best approach. But we urge the committee to give serious consideration to designing a private sector solution to the problem. There is a good deal of support in the business community to help bring about that private sector solution.

Thank you very much.

[The prepared statement of Mr. Bliss follows:]

STATEMENT OF DONALD T. BLISS, ESQ., PARTNER, O'MELVENY & MYERS, ON BEHALF OF THE NATIONAL ASSOCIATION OF MANUFACTURERS

SUMMARY

High unemployment and the corresponding loss of job-based health insurance coverage is creating complex medical and economic problems for a growing number of Americans. Other factors, including a fundamental restructuring of certain segments of American industry and large federal deficits further complicate this problem. The establishment of new entitlements or creation of additional state bureaucracies at this time is ill-advised; rather, assistance in designing a response to the medical and economic problems faced by the unemployed should be sought where the problem is occurring—in the private sector.

NAM's private sector approach calls for Congressional consideration of the following options: (1) *90-day period.* Mandated extension of health insurance coverage for laid-off workers tied to the employer's deductibility for health benefits now permitted under the IRS code; coverage must equal what is provided to other workers; (2) *One year period.* The option of continuing the same coverage, but with financing borne by the former worker, at group rates contracted/negotiated with the insurance carrier by the employer; *or* development of a "low option" (low cost) basic insurance package with financing borne by the former worker at negotiated group rates as described above; (3) *Unemployment Compensation.* Premium costs for additional health insurance (beyond the mandated 90 days) could be paid by the former worker out of amounts received from Unemployment Compensation; Title V of the Social Security Amendments of 1983 authorizes voluntary deductions for this purpose; (4) *Spouse Coverage.* In cases where an employed worker's spouse loses his/her job due to lay-off, the working spouse's employer would be required to offer immediate insurance coverage to the laid-off worker; coverage, financed by the active worker, would be comparable to that given to other spousal coverage offered by the company; (5). *Employment Re-entry.* Upon re-entry to a new job (or former job), health insurance coverage at the new place of employment would become effective by at least the 31st day of employment.

STATEMENT

Mr. Chairman and members of the Subcommittees on Health, and Public Assistance and Unemployment Compensation, my name is Donald T. Bliss, and I am a Partner with the law firm of O'Melveny and Myers. From 1969 to 1973, I was an assistant to the Secretary of Health, Education and Welfare. I am also a member of the National Association of Manufacturer's Policy Subcommittee on Health Care. Accompanying me is Sharon Canner, health care analyst at NAM. Today, I am representing the NAM, an organization of over 13,000 corporations of every size and industrial classification located in every state. Our members employ 85 percent of the workers in manufacturing employment and produce over 80 percent of the nation's manufactured goods.

We wish to take this opportunity to commend both Subcommittees on their leadership in seeking solutions to the many problems faced by the unemployed, in particular the interest you have shown in regard to the medical/economic hardships caused by loss of job-based health insurance coverage. The NAM looks forward to working with you on this difficult, but vital task.

Private health insurance in this country covers 160 million workers and their families. Much of this insurance is provided by employers through group plans. Loss of employment often means loss of insurance coverage for the worker and the worker's family. A double digit unemployment rate results in a growing number of individuals who can no longer afford basic physician and hospital care. Naturally the pressure is growing for public action in this area.

The National Association of Manufacturers considers the loss of insurance coverage a grave problem. All of industry is affected by this problem in one way or another. When health care coverage for laid-off employees expires, these persons must of necessity seek care for themselves and their families through the publicly fincanced system, Medicaid. Companies that have not exerienced job loss appear to be subsidizing health care for the unemployed. It is we, the employer community which supports that medical system through the tax dollar. Further, when individuals cannot cover medical bills through their own funds and/or insurance, hospitals in particular, incur bad debts and the costs are then shifted to others in the private sector.

In considering the health care needs of the unemployed, the NAM has studied the various proposals that have been offered by members of Congress. These proposals have meritorious objectives and their sponsors should be applauded for their efforts to alleviate the physical and economic difficulties being faced by laid-off workers. However, proposed solutions to a complex problem must not create additional administrative or bureaucratic complexities which would stifle legislative attempts to meet the needs of citizens who are temporarily without insurance coverage. Specifically, we should not create new entitlements, expand existing programs, establish 50 individual state programs or pools. Rather, assistance in resolving this problem should be sought from those in the private sector.

If it appears likely that Congress intends to legislate health care coverage for the unemployed, the NAM has prepared a set of considerations that might assist in development of such an effort. Certain basic elements are also included in this private sector approach. Later in our testimony, we will comment specifically on H.R. 3021, a bill introduced by Representatives Waxman and Madigan to provide health benefits to laid-off workers through a Federal-State entitlement program.

CONSIDERATIONS

The National Association of Manufacturers believes that adequate care should be available to all legal residents of the United States at reasonable cost. Portions of our population, at one time or other, will lack sufficient medical coverage and some of these gaps can be filled by the extension of private sector plans, while others such as coverage for the poor and near poor are legitimate areas of government responsibility, such as Medicaid. Individuals involuntarily and temporarily separated from their jobs belong to the former group and are not appropriate areas of government responsibility.

The loss of jobs and corresponding loss of employment-based health insurance is both a current problem requiring action and may be a long term problem requiring additional measures.

Any health care plan to aid the unemployed should seek to meet temporary basic primary care needs. Aid of this nature must not interfere with the individual's continuing the job search and return to the workforce.

Health insurance for the unemployed should seek to continue the traditions by which medical care is provided to other portions of the population by offering alternative health care options. Appropriate coverage will assist the individual during this critical period of transition and furnish the support needed to continue the job search.

A PRIVATE SECTOR APPROACH

With these considerations in mind, the NAM recommends the following approach to meeting the health insurance needs of unemployed workers should legislative options be entertained.

Extension of benefits.—The starting point for this private sector approach is the existing job-based group health plan. At present, many companies offer former workers extended benefits ranging from one month to two years depending on length of service and the particular industry involved. Therefore continued coverage for a period such as 90 days could be mandated. This could be tied to the employer's deductibility for health benefits now provided under the IRS code, although other approaches are also valid. Coverage would maintain the former employee's coverage and thus would be comparable to that which is provided for other workers. The expense would be borne by the same arrangements that existed before lay-off, i.e., totally employer paid, or combined employer/employee financed.

Beyond the 90 day period a second phase would then take effect. This phase, effective for one year, would offer the former worker several choices:

(a) The option to continue the same coverage, but with the cost paid by the former worker, at group rates contracted/negotiated with the insurance carrier by the employer (special arrangements would be made for self-insured companies).

(b) Development of a "low option" basic insurance package with financing arrangements the same as (a). The intent is to give the individual (and family) basic protection at a minimal cost.

Unemployment compensation.—Title V of the Social Security Act Amendments of 1983 provides, at a person's request, for reduction of portions of Unemployment Compensation to finance health insurance. Those unemployed who voluntarily allow for a deduction from the UC benefits check could have those amounts used to cover premium costs as mentioned above under "extended benefits." However, we believe that this election should be totally voluntary and would oppose any mandated diversion of monies from the UC trust funds to finance health insurance coverage. In previous testimony before Congress, the NAM has opposed any diversion of monies from UC benefits for purposes other than as intended by UC law.

Family coverage.—In the event that an employed worker's spouse loses his/her job to lay-off, the employer of the working spouse would be required to offer insurance coverage to that individual immediately upon expiration of the 90 day period. The premium financed by the active worker for this family coverage should be comparable to that charged for similar family coverage offered by the company.

Employment reentry.—To facilitate reentry of workers to new jobs, (or former jobs), health insurance coverage at the new place of employment could be made to become effective by at least the 31st day of employment. Special open enrollment or other timing restrictions should be eliminated under these circumstances.

HEALTH CARE FOR THE UNEMPLOYED ACT OF 1983

Mr. Chairman, I would now like to comment on H.R. 3021, the Health Care for the Unemployed Act of 1983. Sponsored by Representatives Waxman and Madigan, this bill would establish a Federal-State entitlement program under Title XXI of the Social Security Act to provide basic health benefits to unemployed workers and their dependents who have lost private health insurance coverage. The legislation consists of three parts: (1) a publicly-financed program of basic health benefits; (2) a requirement that employers offer continuation coverage to laid-off workers, and open enrollment to unemployed spouses of their employees; and (3) a discretionary grant program for hospitals serving large numbers of unemployed.

It is estimated by the Congressional Budget Office that the Health Care for the Unemployed Act of 1983 will cost $2.7 billion in fiscal year 1984 and $2.3 billion in fiscal year 1985. While these figures are considerable now, there is no guarantee that once the program is operational that constituency pressure will not result in additional funding. Experience has shown that the federal government has a poor track record in estimating the true costs of new health care entitlement programs. For example, after the enactment of Medicare in 1966, the Social Security Trustees Report estimated that outlays from the Hospital Insurance (HI) and Supplemental Medical Insurance (SMI) Trust Funds would rise in real terms by 5.2 percent and 2.3 percent annually, but instead these programs have grown by 9.3 percent and 10.2 percent annually. By fiscal year 1988 SMI outlays should have been $5.6 billion, but it is anticipated that the program will now cost $36.5 billion.

At the moment this nation is experiencing escalating budget deficits with a corresponding retrenchment in entitlement and social program spending. Any attempt to create a new program would appear to be inequitable, particularly to the poor and elderly who already have been asked to accept cuts in Medicaid and Medicare. With recent signs that the economy is rebounding, it seems particularly ill-advised to exacerbate deficit spending and fuel inflation once again.

Although the Federal-State program and the grants to hospitals serving large numbers of unemployed will both be repealed on October 1, 1986, under H.R. 3021, it is always politically difficult to "take away" a program once it is underway. As members of this Subcommittee, I am sure you are well aware of this fact.

Employer requirements under H.R. 3021 include the extension of health benefits to laid-off workers and their families for three months at employer expense beginning in 1985 and immediate open enrollment to unemployed spouses of workers and families beginning in 1984. Compliance is tied to the Fair Labor Standards Act. As indicated in earlier parts of this testimony, the NAM favors the extended benefits and open enrollment requirements, believing that this is a reasonable approach for dealing with the problem.

The employer provision, on the other hand, does raise an additional point of concern to us. Unlike the other major aspects of the legislation, the employer provision does not sunset, but continues indefinitely. This lack of flexibility in the bill forever locks in the employer. Changing economic conditions, continued industrial restructuring in the future, and a host of other factors may tie the employer's as well as the government's hands.

In summary, we believe that a new entitlement program is unwise at this time. Rather, we would call your attention to what the private sector is already doing to assist the unemployed and NAM's proposal in this regard.

CONCLUSION

Central to NAM's private sector approach is its administrative simplicity and use of already existing structures. A majority of companies, both large and small, provide a group health plan administered by the company or its agent. Use of this structure to assist the laid-off worker would require no new government agency or staff to operate the program. This approach could be implemented immediately to alleviate the short term need and could continue to offer extended benefits, family coverage and quick re-entry eligibility for the long term as well. Appropriate health insurance coverage for the laid-off worker will assist the individual during a time of difficult transition.

This approach does not create a new federal entitlement or 50 separate state bureaucracies with their accompanying administrative overhead costs. It recognizes that programs for the poor and elderly have already been severely cut and that to offer federal assistance to yet another group, although their needs are great, would be inequitable.

Thank you for this opportunity to present our views on health insurance coverage for the unemployed. We look forward to working constructively with this Subcommittee and Congress on this and the other critical issues affecting our nation's economic recovery.

ADDENDUM

It is our understanding that Congressman Rangel (D-NY) has offered a proposal to provide health insurance coverage for the unemployed through block grants to states and a new Part B of Title XX. The private health insurance requirement is similar to that contained in H.R. 3021 with the exception of tying compliance for benefits extension and spouse coverage to the employer's tax liability. We would have no objection to this provision. However, as we indicated earlier, this provision should sunset along with the other provisions of the bill in 1986. Overall, the NAM is opposed to any new programs requiring additional federal funds for reasons stated earlier.

Chairman **Ford**. That is not the case with the chamber of commerce according to the testimony. On page 2 you talked about where the unemployed have no health insurance there may be help from family members or charitable organizations and many physicians and hospitals. The Memphis Regional Medical Center testified a minute ago that they have severe financial problems in urban cities like Memphis with unemployment over 10 percent. They have submitted waivers to HHS, and they are still faced with severe financial problems. I am not sure that with the high health care costs today that family members and charitable organizations will be able to pick up the kind of cost that is involved in providing the type of health care coverage that would be needed for the unemployed.

I would like the chamber to try to respond.

Mr. **Ozga**. We are aware of the problems public hospitals are facing. But if I heard the gentleman's testimony correctly he was also including a lot of people who are without health insurance, irrespective of employment. We have to differentiate these groups and stick to the purpose of this hearing. Clearly the problem is twofold.

Chairman **Ford**. I would agree, it is twofold. I think we talked about it with some of the other witnesses today. That is an area which I guess we will have to address. The Rangel bill addressed that particular problem, those who live below the poverty level, whether or not their employment status might be that of someone who is working on a minimum wage job without the type of health coverage needed, whether or not it should be part of the legislation we are dealing with.

Mr. **Ozga**. There is no question this is a sticky wicket. We have debated this point long and hard within the chamber in our policymaking group. In the end we have to get back to basic questions. Where is the money going to come from for the Federal Government to pay for it? If we are talking about additional costs to employers who had to layoff employees in the first place, what would the response be? Continued layoffs, or other cutbacks?

We are only going to aggravate the problem. More attention devoted to where existing options are available for people to get health insurance. We don't think they are being utilized as much as possible.

Chairman **Ford**. So you are not totally opposed to the concept of providing health care protection?

Mr. **Ozga**. No, not so long as the existing options are used. Not a new Federal program for that purpose. Or additional burdens on employers.

Chairman **Ford**. Mr. Moore.

Mr. **Moore**. Thank you, Mr. Chairman.

I certainly agree with Mr. Ozga's comments about putting additional expenses on the employer. The employer is having problems now and it would aggravate that. Certainly that is why I find it hard to understand why we are opposing the tax cap as a way that would not affect, we don't think, the employer but would be a way to fund the program.

Mr. Chairman, I don't think there is any point in getting into this in greater detail at this point because the two witnesses who commented on tax caps, Mr. Goldbeck and Mr. Ozga, have both indicated they are opposed to it. What I would like to ask is in the case of Mr. Goldbeck, is for some additional information since his prepared testimony doesn't get into what he commented on orally.

I would like for you to furnish to my office, if you would, the information you commented upon. I understood you to say 50 percent of the employers are at the $2,100 level already. That is contrary to what we are hearing from OMB and others. So what information you have on the tax cap to help me better understand it would be appreciated. I am not sure I have that information now.

Mr. **Goldbeck**. Congressman, I said that approximately 50 percent of the very large employers, not of employers nationally. When looking at the tax cap issue there is absolutely no relevance to trying to mix together the small employers, which as you heard from Mike's testimony, only 57 percent have health insurance. Therefore, by inference, the other 43 percent don't. So they don't even fit in the tax cap issue to begin with.

As a small employer myself I know by and large even the 57 percent that do, don't have anywhere near the $2,100 level of benefits. The real issue is what happens with the sort of Fortune 1000, the very large employers that have a period of history of developing expensive comprehensive benefit plans. I stress, nobody has finite numbers, but approximately, based on our surveys, meetings we have had and discussions we have held around the country, 50 percent are either at or very close to the tax cap level now of $2,100. What is significant about that from a budget planning standpoint, revenue projection standpoint, impact on numbers of employees who would change behavior, potentially all the other reasons why the tax cap might be favored by one of you, is that only a very few of those employers are significantly above the tax cap, in other words, at $2,900 or $3,000 or something level of benefit package. That is the distinction I was trying to draw.

Mr. **Moore.** That distinction I don't find distinct. The point as Mr. Stockman indicated is we are talking about a very small number of people, not the general work force and not the general employer, but where it is a grave problem. I would like any raw data or conclusions you have.

Mr. **Goldbeck.** Yes, sir.

Mr. **Moore.** Mr. Ozga, you had two reasons for opposing a cap that interested me that bear further looking into from my point of view. I would like you to furnish me information you have about this being unfair to female, older and handicapped workers who live in high health cost areas. That has not been brought to my attention before.

Your last point also caused interest for me. That is that this would actually increase health care costs by thwarting competition. That runs counter to evidence we have heard before. I would very much appreciate receiving whatever evidence or information you have to substantiate these two points.

Mr. **Ozga.** I would be glad to supply that for the record.

[The information follows:]

Chamber of Commerce of the United States,
Washington, D.C.

Mrs. Margaret Hoffman,
Longworth House Building,
Washington, D.C.

Dear Ms. Hoffman: Per your request, please be advised that the proposed tax cap on employer paid health insurance premiums would discriminate against certain workers and would thwart competition among health care providers and insurers.

DISCRIMINATION AGAINST CERTAIN WORKERS

Workers who live in certain areas of the country—Northeast, Far West—where health care costs are higher than other parts of the country would be taxed, while those workers living in less expensive health care areas would not. In addition, female, older, and handicapped workers—who use the health care system two to three times more than other workers (and, as a result, incur more health costs) require more expensive health care protection and would be unfairly taxed.

COMPETITION IN HEALTH CARE

Generally, the premiums for health maintenance organizations (HMOs)—for a long time, the only form of competition to the fee for service practice of medicine supported by conventional health insurance—tend to be higher than those of traditional indemnification plans, although the benefits provided tend to be greater in number. Employees may decide not to enroll in an HMO if they will be taxed and thereby reduce the market for these alternative delivery systems.

I hope this letter clarifies our testimony delivered earlier this year to the House Ways and Means Subcommittee on Health. Please let me know if you have additional questions.

Cordially yours,

Jan Peter Ozga,
Director, Health Care.

Mr. **Moore.** Thank you, and furnish me personally.

Mr. **Romig.** I am Mike Romig, director of employee benefits for the U.S. chamber. Before the committee considers this legislation further I would like to remind it of the implications of the legislation. Essentially when Congress passed ERISA in 1974 it made two crucial decisions. First, it decided regulation at the Federal level of employee benefits ought to be by the U.S. Department of Treasury and U.S. Department of Labor.

Second, it decided that the regulation of employee benefits ought to be pre-empted from the States. The legislation before us seems to violate both of these concepts. First, it introduces the Secretary of HHS in the regulation of employee health care benefits. Second, it gives to the States the right to newly regulate employee benefit plans in the health care area.

I would hope that the members of the committee would carefully weigh these decisions in this area and see what might be worked out with respect to ERISA before it moves on this legislation.

Thank you.

Chairman FORD. The committee would like to thank the panel.

The committee will recognize the Health Insurance Association of America, Mr. James Dorsch, Washington counsel; Blue Cross and Blue Shield Association, Mary Lehnhard, vice president, Office of Government Relations; and also Mr. James Krauskopf, Commissioner of the New York City Human Resources Administration. All three of the witnesses will come to the witness table at this time.

Mr. DORSCH. Thank you, Mr. Chairman.

Mr. FORD. Mr. Dorsch, you are recognized at this point.

STATEMENT OF JAMES A. DORSCH, WASHINGTON COUNSEL, HEALTH INSURANCE ASSOCIATION OF AMERICA, ACCOMPANIED BY J. MARTIN DICKLER, ACTUARY

Mr. DORSCH. Mr. Chairman, my name is James Dorsch, Washington counsel for the Health Insurance Association of America. I am accompanied by J. Martin Dickler, actuary for the Health Insurance Association.

In my oral remarks, I would like to make three points. First, we would like to set up programs for uninsurable individuals in every State, as we have in Connecticut, to guarantee availability of health insurance to all Americans at no cost to the Federal budget. These programs for uninsurable individuals are particularly pertinent at this point since all laid off employees are not indigent. Establishment of these State programs would not have an adverse effect on the Federal budget.

We note that H.R. 3183, introduced by Congressmen Frenzel and Jenkins, would require all employers to, one, provide a 30-day open enrollment period for employees with laid off spouses; two, continue coverage for 90 days after layoff; and, three, provide opportunity for conversion into an individual health insurance policy when group coverage ends without medical evidence of insurability. That provision could be amended to also require employers who self-insure to participate in Connecticut-type guaranteed availability plans, thus removing the ERISA barrier which currently exists.

In fact, if the bill were so amended, the conversion requirement would not be needed since all Americans would then be guaranteed the availability of health insurance regardless of their medical condition.

Point two: H.R. 3021, operating under the Fair Labor Standards Acts, imposes on employers the continuation of coverage of spouses if their spouses are laid off. It requires employers with insured plans to provide the right to convert to an individual health plan, but does not impose a similar obligation on uninsured plans.

We strongly oppose this feature of the bill and urge instead the approach taken in H.R. 3183; that is, enforcing the private insurance requirements on all employers through changes in tax liability.

The third point is the employee health tax. The administration has asked Congress to levy a tax as part of its 1984 legislative program. It has now proposed that the tax not yet enacted, be increased to finance grants to the States for health insurance for the unemployed, although insisting that the purpose of the tax is to contain rising health care costs—not to raise revenue.

The health insurance industry opposes this as discriminatory, unfair, and one that will do nothing to stop health care cost inflation nor will it raise the revenue suggested as labor management negotiations rearrange the employee benefit package. It penalizes the older workers; it penalizes those in hazardous, high-risk occupations. It is a form of double taxation. It unfairly affects certain geographic areas and could result in reduced coverage for preventive care services.

Mr. Chairman, the Rand study on health care costs published in November 1982 often referred to by proponents, by the health tax proponents, states, and I quote: "People would probably not reduce their insurance coverage uniformly—dental care, ambulatory care, drugs, and similar services would probably become uncovered—hospital insurance coverage would probably be the least changed." I think there is general agreement that it is soaring hospital costs that are the heart of the problem today.

The study raises another concern. It points out that while a typical proposal for taxing employees on behalf of employer-paid contributions could reduce hospital use by $7.6 billion, hospitals could recover more than $5 billion by raising prices charged the remaining patients, the Government and insurers. Well, with the passage of the Social Security Amendments of 1983, putting medicare on the new DRG basis set by HHS, it wouldn't be the Government that is hit by the new round of high prices. It will be the rest of us that are picking up the whole thing.

The end result will be health insurance that is more expensive, people having less protection, hospital prices higher for those people who need their services, with hospitals getting the same amount of revenue to cover their overall fixed operating expenses. In essence, as a hospital cost containment device, the employee health tax is a meat ax that misses its mark.

The same study concludes on yet another cautionary note. Effects on consumers' health status are as yet unknown. We believe encouraging people to cut back on preventive services will have a detrimental effect on consumers' health status. The most sensible approach to keeping hospital costs under control is prospective payment reform that applies to all patients—not just medicare patients.

There is no reason why the Congress should try the untested theory of taxing health insurance premiums, and every reason why they should not.

Mr. Chairman, in addition to my full statement, I would like to submit for the record a white paper on health care tax prepared by Mr. Dickler.

Thank you.

[The prepared statement and attachment follow:]

STATEMENT OF JAMES A. DORSCH, WASHINGTON COUNSEL, HEALTH INSURANCE ASSOCIATION OF AMERICA

My name is James A. Dorsch. I am Washington Counsel for the Health Insurance Association of America. I am accompanied by J. Martin Dickler, Actuary for the Health Insurance Association of America. The HIAA is a trade association of approximately 320 companies which together write over 85 percent of the country's commercial health insurance. We appear today on their behalf.

We are pleased to have this opportunity to explain the types and extent of health insurance coverage available to people who are laid off or otherwise terminated from employment and to make some comments on some of the ideas expressed to date.

Most people in the United States obtain their health care coverage through their employment. More than four-fifths of those insured in the private sector are covered in this fashion. Insurance companies offer a variety of options under which health care protection can be continued for the individual and his family. The major problem lies with who will finance the premiums and for how long.

There are a variety of mechanisms for continuing coverage. They include the group conversion provision, temporary continuance under the group insurance policy, the regular insurance marketplace, and state pools for high risk or uninsurable lives. Let me explain.

Conversion privilege

The most common mechanism is the group conversion policy. It has been offered by group insurers for many years.

Many states require that a conversion privilege provision be included in group policies issued in their state. Most insurers offer a conversion privilege in all group policies, whether or not required by state law, to provide continued insurance protection when employment-based coverage ends. The terminated employee either needs protection temporarily until group coverage is available at new employment or a regular, longer-term individual policy because of other circumstances. In either case, the group conversion policy is issued without medical underwriting, providing that application is made within a prescribed period (usually 31 days).

This is an extremely valuable right, since the employee or his dependents may be in poor health. The insurance company is obliged to issue insurance regardless of their state of health, the only qualification being if there would be an overinsurance situation because of other coverage the employee has.

Historically, group conversion policies provided basic hospital and surgical benefits on a scheduled basis. In recent years, several states have passed legislation setting minimum standards for benefit levels provided under group conversion policies. These have greatly increased the scheduled limits available under basic coverage. Also, about 13 states now require that a group conversion major medical policy also be made available, if the group coverage was major medical. These policies provide protection for both in- and out-of-hospital expenses, and feature high coverage limits. These policies are also issued on a non-medical basis if the employee makes timely application.

It should be noted that employer and union self-funded benefit plans are not subject to state regulation (per ERISA, Section 514) and, consequently, do not have to offer a conversion provision. However, many self-funded plans do include a conversion privilege and have made arrangements with their administering insurance company to provide it.

Continuance (temporary) under the group insurance policy

In recent years there has also been a trend toward increased use of the employer's group policy to extend options available to terminated employees.

Customarily, employer contributions for coverage extend to the end of the month following the month in which active employment ceases. Some unions, notably Steelworkers and Autoworkers, have negotiated continuation of employer payments for up to an additional twelve months following layoff.

Beyond this, many benefit plans provide for insurance to be continuable under the group policy on payment by the individual of the required premium. In recent years, there has been a trend towards increased use of the group policy to extend such options available to laid-off employees. At the end of this period, usually one year or less, the employee may then choose a group conversion policy. Thirteen states currently require some form of this extension under group policies.

The conventional insurance market

Also, upon leaving employment, an employee may elect to purchase individual or family health insurance coverage in the conventional insurance marketplace of carriers, Blue Cross/Blue Shield plans, and HMOs. A broad range of policies is available from insurance companies, subject to their underwriting requirements. Some companies offer short-term, temporary coverage (of 3–6 months duration).

Guaranteed availability of health insurance

Six states provide persons who are uninsurable or in poor health an additional option. Connecticut, Rhode Island, Indiana, Minnesota, North Dakota, and Wisconsin have created associations or state pools to issue individual insurance policies to such persons. A seventh state, Florida, is in process of formation. This type of arrangement can benefit not only terminated employees who do not elect a group conversion policy, but in fact any resident of the state employed or otherwise. This is an important development in removing barriers to health insurance protection.

We would like to set up programs for uninsurables in every state, as we have done in Connecticut, to guarantee the availability of health insurance to all individuals at no cost to the federal budget. However, ERISA is a major barrier to our seeking state laws setting up these programs. ERISA preempts state laws to the extent those laws require self-insured plans to participate in the state pools. Thus, self-insured plans are effectively shielded from the economic burden of the pools, a burden which falls on an ever-decreasing base caused by existing legal barriers to equitable competition. We feel strongly that all competitors in the employee health benefit market should share proportionately in any pool losses. The problem could be solved either by an amendment to ERISA or by legislation authorizing insurers to set up such pools and requiring all employee health benefit plan funding mechanisms to participate in such a pool as a condition of income tax deductibility.

These programs for uninsurable individuals are particularly pertinent at this point since all laid-off employees are not indigent and establishment of these state programs would not have an adverse impact on the federal deficit.

We note that H.R. 3183, introduced by Congressmen Frenzel and Jenkins, would require all employers to (1) provide a 30-day open enrollment period for employees with laid-off spouses, (2) continue coverage for 90 days after lay-off, and (3) provide an opportunity for conversion to an individual health insurance policy when the group coverage ends without medical evidence of insurability. That provision could be amended to require employers who self-insure to participate in Connecticut-type guaranteed availability plans. In fact, if the bill were so amended, the conversion requirement would not be needed, since all Americans would then be guaranteed the availability of health insurance regardless of their medical condition.

If the committee decides to act favorably on this legislation we strongly urge such an amendment and will be happy to work with the committee staff in the development of appropriate language.

H.R. 3021, on the other hand, operating under the Fair Labor Standards Act, directly imposes on employers only the requirements pertaining to laid-off spouses and continuation of coverage after lay-off. It then directs the States to require employers with insured plans to contract for a right to convert to an individual health plan, but does not impose a similar obligation on uninsured plans.

Mr. Chairman, self-insured plans are a major force in the market today. We estimate that over one-third of employee group plans are self-insured. We also have reports from major insurers that up to half of their new group business is in administering self-insured plans. In many cases the major difference is simply that the insurer pays claims with the employer's check-book rather than its own. There is no reason a self-insured employer cannot meet the same obligation to its employees as an insured plan. By so discriminating, H.R. 3021 does two things. First it gives self-insurance a further competitive advantage over insurance. Second, it unnecessarily deprives a very large segment of the work force of one of the benefits intended by the bill.

The HIAA, therefore, strongly opposes this feature of the bill and urges instead the approach taken in H.R. 3183, i.e., enforcing the private health insurance requirements on all employers through changes in tax liability.

Employee health tax

The Administration has asked Congress to levy a tax on employee health plans as part of its fiscal year 1984 legislative program. it has now proposed, in testimony to the Senate Finance Committee on April 27, that the employee health tax, not yet enacted, be increased to finance grants to the states for health insurance for the unemployed, although insisting that the purpose of the tax is to contain rising health care costs, not raise revenue.

The health insurance industry opposes this proposal as discriminatory, unfair, and one that will do nothing to stop health-care-cost inflation, nor will it raise the revenue suggested as labor-management negotiations rearrange the employee benefit package.

Among the arguments against such a tax are the following:

It penalizes older workers.—Elderly groups tend to use health care more frequently than younger, healthier workers. Hence, the cost of health insurance for a group which includes more than the average number of older workers not only will be higher but could discourage many employers from hiring the older worker. Under the Administration proposal, these groups will be adversely affected by a cap, while younger groups with similar coverage may not be taxed.

It penalizes those in hazardous, high-risk occupations.—Some groups, such as iron workers or coal miners, are usually considered a higher "risk," and are typically charged higher health insurance premiums. These groups could be unfairly taxed while other groups with similar coverage-such as clerical workers—would be unaffected.

It is a form of "double taxation."—The Health Insurance Association of America estimates that Medicare and Medicaid payment practices resulted in $7.9 billion being shifted to patients covered by private health insurance in 1983 to make up for government underpayments to hospitals. For the government to shift these costs to the private sector and then put a tax on the resulting higher insurance premiums is patently unfair.

It unfairly affects certain geographic areas.—The cost of health care is higher in some areas, such as large metropolitan cities. A single national tax cap does not take geographic differences into account, and thus would particularly penalize those in high-cost areas. Conversely, it would allow the tax-free purchase of much more generous benefit plans by those in low-cost areas.

It could result in reduced coverage for preventive care services.—As employees scramble to reduce their overall premium rates, essential preventive care services such as dental care, vision care, mental health benefits, and alcohol and drug abuse services may be dropped from benefit plans. Dropping these benefits does nothing to reduce hospital costs, and in the end may have the opposite effect.

Mr. Chairman, all of those in the private sector who have the most to gain from effective hospital cost containment—the employers, the unions, the insurers—in essence, all of those in the private sector on the paying side of the equation—say the employee health tax will be ineffective in curbing rising costs and are opposed to its enactment. Those who have the most to gain by its failure to work, i.e., the health providers, say it will work to de-escalate hospital inflation. However, it is a fact that the medical expense people fear most is hospital expense, and it is hospitalization insurance that will be the last, and least, effected by this proposal.

On this point, Mr. Chairman, I would like to call attention to the Rand study on health care costs published in November 1982, a study often referred to by the health tax proponents as demonstrating the efficacy of the health tax in reducing health costs, a conclusion to which we obviously take exception.

The study states, in any event, that while the increased cost of employee health insurance resulting from the tax would reduce the over-all amount of health protection available:

"In fact, people would probably not reduce their insurance coverage uniformly but would follow some simple principles in making selective reductions. Just as insurance was historically first chosen to cover the highest risk services (e.g., hospitalization) and only later extended to cover lower risk services (e.g., physician office visits, dental care, psychiatric visits), retrenchment in coverage would probably follow similar patterns. Dental care, ambulatory care, drugs, and similar services would probably become uncovered or, at least, covered only with very large yearly deductibles of perhaps $500 or more, rather than currently typical deductibles of $150 to $200. In terms of effects on aggregate medical care market demand, most purchases of these services would be uninsured. Hospital insurance coverage would probably be least changed, because the financial risks are greatest for hospitalization."

The study raises another concern. It points out that while a "typical proposal" for taxing employees on half of employer-paid contribution could reduce hospital use by $7.6 billion, the hospitals could recover more than $5 billion "by raising prices charged the remaining patients, the government, and insurers."

Well, with the passage of the Social Security Amendments of 1983 putting Medicare on the new DRG-prospective basis, set by HHS, it won't be the government hit by the new round of higher prices—it will be the rest of us.

The end result will be health insurance that is more expensive, people having less protection, hospital prices higher for those that need their services, and hospitals get the same amount of revenue to cover their over-all fixed operating expenses.

In essence, as a hospital cost containment device, the employee health tax is a meat-axe that misses its mark.

The same study concludes on another cautionary note, "Effects on consumers' health status are as yet unknown but will have considerable effect on the desirability of such changes in public policy."

We believe that encouraging people to cut back on preventive services will have a detrimental effect on consumers' health status.

The most sensible approach to keeping hospital costs under control is prospective payment reform that applies to all patients, not just Medicare patients. Rising costs are not just a Medicare-Medicaid problem but a national health care problem as well. A prospective all-patients system will force cost-saving incentives into the structure of hospital payments and operations and will have many times the impact of the band-aid approach of taxing workers' health insurance premiums.

We are beginning to see that prospective payment systems that include all-payers, including Medicare, now in place in four states, can work. There is no reason why the Congress should try the untested theory of taxing health insurance premiums—and every reason why it should not.

Again, HIAA and its member companies share this Committee's concern over the plight of the unemployed. We appreciate the opportunity to present this explanation. I will be pleased to respond to questions.

BACKGROUND FACTS—GROUP CONVERSION POLICIES

Most states require a conversion provision in group policies issued in their state. Most insurers include a conversion provision in all group policies, whether or not required by the state in which the group policy is issued. Self-insured employers usually have their carrier issue conversion policies even though no group policy is in force. Group conversion policies are issued non-medically, provided the employee applies within a presecribed period (usually 31 days) after termination. The employee may insure himself and eligible dependents. Most policies are guaranteed renewable, i.e., cannot be individually cancelled by the insurance company. An insurance company does not have to issue a conversion policy if the terminating employee happens to have other coverage and would be over-insured.

The types of coverage are as follows:

(a) Basic hospital and surgical:

These policies cover hospital room and board up to a specific dollar limit for a specified number of days (usually 30, 70, or 120 days). Hospital special services are covered at actual charges up to a specified limit, (e.g., ten times the room and board daily limit). Surgical charges are covered up to scheduled amounts. Several states have established minimum standards with respect to the room and board limits and surgical schedule maximum.

(b) Major medical:

About 13 states require that group conversion major medical policies be offered if the group policy provided major medical coverage. These policies cover both in- and out-of-hospital expenses typically included in major medical policies, except that some expenses such as room and board and surgical are subject to inside limits. In most states, a $500 deductible applies, or base-plan benefits if higher. In seven states, a $100 deductible is required.

Since group conversion policies are issued non-medically, they appeal to terminating employees whose health has deteriorated. As a result, claim experience under group conversion policies is higher than under standard underwritten policies with comparable benefits. As an offset, however, there is an expense savings since either reduced or no commissions are paid on conversion policies. Some companies require the employer to pay a group conversion charge when a terminating employee buys a conversion policy. This charge helps defray the cost to the insurer of providing the conversion privilege.

HEALTH CARE TAX . . . A CRITICAL VIEW

FEDERAL PROPOSALS TO TAX EMPLOYEES ON HEALTH INSURANCE PREMIUMS PAID BY EMPLOYERS

The Federal Administration is proposing to tax employees on employer contributions to group health insurance plans. Advocates claim that the tax would both increase Federal revenues and help contain health care costs. But in our view, this kind of tax would fall upon taxpayers in a haphazard, unfair manner. The actual revenue generated could prove to be small, although the administrative burden on employers could be costly. As a device to contain health care costs, this tax is likely to accomplish little or nothing.

In the following pages, the tax proposal is explored as a revenue raiser and as a health care cost containment measure. Also included is a commentary on a recent study by Amy K. Taylor and Gail R. Wilensky entitled "Tax Expenditures and the Demand for Private Health Insurance."

PROPOSED TAX AS A REVENUE RAISER

The desire of the Administration to narrow the Federal budget deficit is understandable and laudable. We can also understand the initial attractiveness of employer contributions to group health insurance as a new source of taxable income. Before embarking upon such a course, however, the adverse impact of this kind of taxation on both employees and employers, and the likely amount of revenue that would be generated should be carefully considered. Let us review each of these.

Impact on employees

Group health insurance is purchased by employers for the benefit of employees, usually with the advice of experts. The employer usually selects the coverage, except when the insurance plan is the subject of collective bargaining. Normally, the cost of the plan is either borne entirely by the employer, or largely by the employer with some employee contribution required. If the employer's cost were to become taxable income to employes, such cost would have to be allocated to each employee as imputed income, whether or not there is an exemption of some dollar amount. To be fair, each employee's imputed income should be based upon the actuarial value to him of the health insurance plan.

Essentially, this means determining annually each employee's share of the employer's cost as a function of the principal actuarial factors: age, sex. coverage for dependents and place to residence. The extent to which this can be done depends upon premium rating practices and available data, which generally differ for small and large groups.

Small groups (under 50 employees)

Let us first consider employees who work for firms with fewer than 50 employees. According to the United States Department of Commerce data, there were 4.3 million firms with one to forty-nine employees in 1980. According to insurance company data, these small groups probably provide employment for over 15 million workers. There are many carriers active in the small group market and each offers a variety of health insurance plans from which an employer can choose.

A common characteristic of plans sold to small employers is that schedules of age- and sex-specific premium rates are used, which are adjusted for the geographic area in which the firm is located. Premium rates may also be adjusted to reflect the industry classification of the firm. With this kind of rate structure, there is a specific premium for each employee reflecting age, sex, dependents covered, type of industry, and locality. Such premium rates represent the actuarial value of the plan to the employee, as calculated by the insurance company, and the employer's share of the premium could be readily used as imputed income.

Table I shows the yearly imputed income for a male employee, age 40 to 44, covered by a comprehensive medical expense plan, assuming premium for that age was used for imputed income. In this example, it is assumed that the employer share of the premium is 75 percent, and the firm has two-to-nine employees. The premium rates used are an average of those in actual use as of January 1, 1983, by five carriers, in three high-cost and three low-cost cities.

It is apparent from Table I that if the employer's contribution were fully taxable, the impact on employees would vary widely from city to city, reflecting regional differences in the cost of health care. A single employee in Los Angeles would have $1,652 in imputed income compared to $714 if he were employed in Greenville, South Carolina. If the employee had dependent coverage, the corresponding imputed incomes would be $5,063 and $2,172. In each case, the Los Angeles employee would have more than twice as much imputed income as his Greenville counterpart.

If only the employer's contribution above a specified "tax cap" were to be taxable, the amount of imputed income would then also depend upon the level of exemption. Table I shows the effect of four levels of tax cap, where each is a uniform amount naitonwide. If the tax cap were set at the level proposed by the Reagan Administration—$840 per year for an individual ($70 per month) and $2,100 a year for a family ($175 per month)—the amount of imputed income would decrease in all six cities. An individual in Los Angeles, in this case, would have an imputed income of $812 while his counterpart in Greenville would have no imputed income. If the Los Angeles employee had dependent coverage, his imputed income would be $2,963, which is 41 times the imputed income of $72 for the corresponding Greenville employee. The use of a nationwide uniform tax cap therefore, would result in inequity in how the tax burden would fall upon taxpayers in small local groups, by reason of their place of residence.

Table I illustrates the unfairness to employees by place of residence. A uniform tax cap that does not reflect age and sex would similarly shift more of the tax burdern to older employees and females, since premiums increase with age and are higher for females than males. If a particular tax cap were to be used, it should be adjusted for age, sex, and locality to preserve the fair allocation of imputed income on the basis of actuarial value (in the case premium.)

TABLE 1.—YEARLY IMPUTED INCOME FOR MALES AGED 40 TO 44, EMPLOYED IN A GROUP OF 2 TO 9 EMPLOYEES

[Employer contribution equals 75 percent of premium for comprehensive medical expense plan.[1]]

City	Exemption amounts:				
	None	$450 individual 1,125 family	$720 individual 1,800 family	$840 individual 2,100 family	$975 individual 2,400 family
Individual:					
Los Angeles	$1,652	$1,202	$932	$812	$677
Miami	1,333	883	613	493	358
New York [2]	1,283	833	563	443	308
Fargo, N. Dak	848	398	128	8	None
Macon, Ga	839	389	119	None	None
Greenville, S.C.	714	264	None	None	None
Family:					
Los Angeles	5,063	3,938	3,263	2,963	2,663
Miami	4,122	2,997	2,322	2,022	1,722
New York [2]	3,966	2,841	2,166	1,866	1,566
Fargo, N. Dak	2,587	1,462	787	487	187
Macon, Ga	2,552	1,427	752	452	152
Greenville, S.C.	2,172	1,047	372	72	None

[1] Based on average of premium rates as of January 1, 1983 of five carriers. Plan includes full maternity coverage. No extra factor for a high-risk industry.

[2] Manhattan.

Current proposals call for a uniform, nationwide tax cap and do not reflect age and sex. In order to have imputed income on the same basis, each employee would have to be assigned imputed income on the basis of the group's computed average premium per employee. This would, however, simply introduce a different form of inequity. Take, for example, a small group of a self-employed 55-year-old accountant and a 20-year-old secretary. Each would have imputed income equal to the average of their premiums, but the secretary would be subsidizing the accountant with respect to allocated imputed income. Speaking more generally, if each small group employee were assigned imputed income on the basis of an average premium, the young would subsidize the old and males would subsidize females. And, of course, there would still be wide difference in tax liability by area as shown in Table I.

Larger groups (50 or more employees)

Larger groups generally have at least 50 employees, and can range to hundreds of thousands. For such groups, premium rating practices are quite different from those described for small groups. Employers with insured plans typically remit monthly "billing" premiums, but the final cost depends upon actual claim experience, expenses and other factors for the policy year. For the present purpose, it will be assumed that billing premium reasonably approximates the cost of the plan.

The premium is typically a specified monthly amount for employee coverage regardless of age and sex. There are one or more additional premiums for dependent coverage, depending upon the number of separate dependent classifications. These are essentially averages that, through experience rating, incorporate the group's actuarial characteristics of age, sex, dependent composition, geographical distribution of employees, type of industry, and claim experience. Average premiums are changed annually to reflect recent claims experience, and the anticipated increases in health care costs for the coming year. This would include provision for inflated health care charges due to cutbacks in Medicare and Medicaid payments, i.e. the "cost shift" to privately insured persons.

Since the per-employee and per dependent unit premiums are adjusted each year and remain broad averages, the actuarial value of the plan for each employee is not readily available. This presents a major problem in determining a fair allocation of employer cost for each employee. The practical approach woud be to use the per-employee premium to allocate imputed income. (With a suitable adjustment when employee contributions are involved.) If this were done, however, young employees would be allocated imputed income in excess of the actuarial value of the plan to them. Older employees would be allocated less imputed income than their actuarial value, and would enjoy a subsidy. Under this system, employers might become reluctant to hire older workers. Likewise, a firm's employees living in low cost areas would subsidize their fellow employees living in high cost areas. In any given group of employees, there would be much "cross subsidy," or redistribution of imputed income for tax purposes. The use of per-employee and per-dependent unit premiums would be in sharp contrast to the fairer distribution of imputed income in small groups, where the age, sex, and area specific premiums reflect actuarial value.

If a uniform tax cap were used in conjunction with imputed income allocated on per-employee premiums, any excess of imputed income over the tax cap would be the same for all employees in the group. The imputed income "after tax cap" would still involve subsidies of the old by the young, females by males and employees in high cost areas by the firm's employees in low cost areas. Under this approach, many inequities are possible. An entire group might escape imputed income if the group's average age were low, or the bulk of the employee lived in low cost areas, or the group enjoyed better than average health. Conversely, a group with a high average age, or heavy concentration of employees in high cost areas, or worse than average health would be much more likely to be taxed. The impact on individual employees could vary sharply. For example, an employee living in Los Angeles might not have any imputed income if the rest of the firm's employees worked in Greenville, South Carolina. This would be very unfair to other Los Angeles workers employed in smaller local firms, and exposed to large taxes. Under this approach, an employee's imputed income would mainly depend upon the overall actuarial characteristics of his firm, and not at all on the actuarial value of the plan to him. This would result in a haphazard distribution of imputed income, difficult to defend or explain to employees.

The alternative to the direct use of per-employee premiums is to calculate the actuarial value of the plan for each employee. This would be a much fairer approach in theory, and would put large groups on the same basis as small groups. A major weakness in this mehtod, however, is that the calculation of actuarial value would require many estimates and approximations, expecially when the employees are widely dispersed. Most employers would not have readily available the kinds of data that would be needed. As an example of the problem, consider a firm based in a high cost city with one sales representative in a low cost city. The actuarial value for the low cost city employee, derived from a broad premium average where all other employees are in a high cost city, will of necessity be based upon theoretical considerations. Many examples could be given to illustrate the difficulty of calculating actuarial value when age, sex and area-specific premium rates are not used. The task of computing the actuarial value of the plan for each Federal employee would indeed be a challenge. And, of course, if a derived actuarial value were used for the allocation of imputed income, the use of a uniform nationwide tax cap would create the same unfair shifting of tax burden as for small groups.

We do not know how the final regulations would prescribe the allocation of an employer's cost to imputed income, or to what extent a tax cap would reflect actuarial factors. It is highly likely, however, that whatever rules are adopted, this tax burden will fall upon millions of employees in an unfair and haphazard manner. A brief summary of the possible impact on employees, depending upon the more likely methods of determining imputed income and the tax cap, is as follows:

(1) If the basis for allocating imputed income were actuarial value, for all groups, small groups could use the premium structure but large groups would have to make many estimates and approximations on theorietical grounds. This would be especially true of self-insured groups, where there is no "premium," and imputed income would be an allocated share of incurred claims. Despite the necessity of approximations for large groups, the use of actuarial value would be the fairest way to allocate imputed income. If, however, a uniform tax cap were used nationwide, without adjustments for age and sex, the tax burden would be unfairly shifted to employees who are older, female, and living in high cost areas.

(2) If imputed income were to be allocated for all groups using per-employee and per-dependent unit premiums, large insured groups could use their premiums. Self insured groups would have to estimate such premiums. Small groups, however, with age-and sex-specific premium rates would have to convert on some basis to a per-employee average. This would mean large fluctuations in imputed income from year to year for small groups, where the age and sex distribution could sharply change with employee turnover. As a result, the allocation of imputed income could become chaotic. The use of per-employee premiums to allocate imputed income would produce much inequity within each employee group, for groups of all sizes. Young employees would subsidize older employees and males would subsidize females. With inequities such as these, an employer may be reluctant to hire older employees or females, as the potential tax liability for all employees is inceased. A large firm's employees in low cost areas would subsidize fellow employees in high cost areas.

The use of a uniform tax cap that did not vary by age and sex would preserve the many cross-subsidies built into the basis for allocating imputed income. An employee's imputed income would depend greatly in the actuarial make-up of the firm rather than the value of the plan to the employee, which is a haphazard method of taxation. Generally, groups with high average ages, or many females, or heavy concentrations of employees in high cost areas, or in poor health, would be most likely to be taxed.

(3) It is possible that because of the different premium structures in use, imputed income would not be allocated in the same manner for all groups of varying size, If acturial value were used for small groups and per-employee premiums for large groups, there would be the same kinds of inequities and haphazardness described above, but they would be different by size of group. This would compound the problem of inequity, as imputed income and tax liability would also vary according to the size of group. For employees changing employment, the change in tax liability could fall in an arbitary and capricious manner.

(4) Whatever method is adopted for the allocation of imputed income, the amount allocated to each employee can fluctuate substantially each year, exposing the employee to tax liability in an unpredictable fashion. This can happen in several ways.

Group claim experience can and does fluctuate from year to year, which is reflected in premium rates, which would then be reflected in imputed income. A group may have good experience for a period of years, and nominal rate increased, and then have "bad years" of experience causing large rate increases. An employee can suddenly be exposed to an unanticipated large imputed income.

Another example of this unpredictability is when an employee changes employment from one group to another with a different age or sex distribution, different mix of employees by geographical area, or different type of industry. Depending on the methods of computation used, his inputed income may change sharply in either direction. For example, a Washington representative of a national bank could suddenly have substantially more imputed income if he or she changed employment to represent a large mining company, with no change in coverage. Similarly, if a representative of a Macon, Georgia firm changed to represent a Los Angeles firm, imputed income would also increase.

Overall, many problems exist in allocating imputed income and in structuring the tax cap. They are such that inevitably many employees will either be lightly taxed or not at all, at the expense of others who will carry a disproportionate share of the burden. Employees will often be exposed to the tax in a haphazard and unpredictable manner, especially upon changing employment and will likely find explanations difficult to understand or accept.

Impact on employers

The imposition of a tax on employer contributions to a group health insurance plan will increase the employer's administrative costs. This will reduce Federal revenue from corporate income taxes to the extent that corporate profits are reduced, or increase the costs of goods and services to consumers. The following considerations illustrate the likely impact on employers.

(1) The vast majority of workers have group health insurance, and although a tax cap may exempt many from paying tax, an employer must be prepared to establish appropriate records for all employees under the group plan. A key expense consideration will be the process by which the employer's cost is allocated to each employee. The more equitable the allocation of imputed income is to employees, the more expensive it is likely to be to administer.

(2) Large employers can have many health insurance plans in effect, but there is usually not more than one at a given location or for a specific bargaining unit. All such plans may not have been rated separately in the past, but now each would have to be separately treated for imputed income purposes. It is not uncommon for a large employer to have dozens or a hundred or more health insurance plans in effect, reflecting collective bargaining activity with many unions. The need to treat a multitude of plans separately for imputed income purposes will increases administrative costs for both large employers and insurance carriers.

(3) Group health insurance premiums are normally changed once yearly, but the annual effective date of change can be at any time in a calendar year. The rate change date might be the anniversary of the group policy, or the employer's fiscal year, or any other date that is mutually agreed upon. Since imputed income to employees must be based on a calendar year, many employers will have to cope with two sets of premium rates in each calendar year, thus driving up the costs.

(4) Special adjustments will be necessary for employees who add or drop dependent coverage during the year. Special calculations will be required for newly hired and terminating employees. Expensive changes to electronic data processing systems may be required.

(5) The new imputed income will increase all employers' social security taxes. This may be especially difficult for the small employer, who will also be pressed by higher bookeeping costs.

(6) Special accounting problems may arise in relating an employer's billing premium to true cost determined after the end of a policy year. To the extent that the employer's true cost is less than premiums, through dividends or other credits, the imputed income to employees should also be reduced, perhaps retroactively. This could entail more complications in accounting and recordkeeping for the employer.

It is ironic that an Administration committed to less regulation and Federal reporting requirements should be proposing a tax change that would add extensive new employer administrative duties.

Amount of revenue likely to be raised

The amount of an employee's imputed income subject to tax will depend upon how imputed income and the tax cap are calculated and applied. Until these matters are decided, the way that the tax burden will be distributed by age, sex, family status, place of residence and size of group is unknown. It is very likely, however, that once the rules are set many employers will explore the opportunities for legitimate tax avoidance. The incentives are to minimize administrative problems and to spare employees from an inequitable and haphazard tax burden. In addition, union leaders will seek methods to avoid the tax on behalf of their membership.

The general thrust of these "tax avoidance" arrangements will be to reduce employer contributions to the group health insurance policy to eliminate tax liability, and to shift an equivalent amount into benefits which are either completely tax free or at most tax deferred for many years. An example of the former is increased vacation allowance, while examples of tax deferred benefits are pension plans and company contributions to savings programs. The particular approach would depend on the amount of contribution to be shifted and other factors such as the distribution of tax liability. Although an employee's contribution to his or her health insurance plan would increase, the tax would have been avoided. The increased tax free or tax deferred benefits will leave the employee in about the same position as before the tax was imposed. Both large and small groups could implement tax avoidance arrangements with the aid of in-house expertise or through consulting firms.

Although it is difficult to forecast the extent to which employers and unions will alter their plans to avoid the tax, it is likely that many will. A tax that falls in an inequitable and haphazard fashion will be difficult for employees to understand and accept. An employer who can offset an unpopular tax is likely to do so. The result will be that much less tax revenue will be realized by the treasury. Even if employers only shift contributions to tax deferred benefits, it could be many years before the treasury realizes any significant tax revenue.

PROPOSED TAX AS A MEASURE TO CONTAIN COSTS

The rapid acceleration of health care costs in recent years has focused attention on the need for improved cost containment. A current theory is that more effective cost containment would result if there were more competitive marketplace forces at work in the health care industry. This marketplace approach is proposed as an alternative to increased government regulation, and includes two popular concepts. One is to encourage the growth of insurance plans with reduced benefits and increased employee cost sharing. The result of cost sharing is expected to be less demand for health services and lower prices because of greater consumer cost sensitivity. This, in turn, is expected to stimulate competitive reactions from providers and ultimately result in cost containment for all patients. The second concept is through competitive alternative health care delivery systems, such as HMOs. The HMO strategy has actually been in place for several years, while the attention given to the cost sharing strategy has increased only recently.

The present lack of marketplace competition is attributed in large part to the tax free status of employer contributions to health insurance. This is said to have encouraged employees to seek "excessive" amounts of insurance, thus insulating them from significant out-of-pocket expenses and making them insensitive to health care costs. The proposed tax is expected to motivate employees to change to lower premium plans with more cost sharing features. Greater cost sharing, as noted, is expected to lead to cost containment.

The need for improved controls on health care costs is not in dispute. The justification of the proposed tax as a cost containment measure, however, rests upon (1) a theory that significant numbers of employees will shift to plans with more cost sharing, and (2) a theory that more cost sharing will actually result in more cost containment for all patients. It is important to consider the plausibility of these theories before complex tax legislation with many adverse results is enacted in the name of cost containment.

Let us first consider the likelihood that a significant number of employees will become covered under plans with more cost sharing. The actual number of employees affected by the tax will depend upon the methods of calculating imputed income and the tax cap, and the prevalence of tax avoidance arrangements. It is clear, however, that for those employees who do become liable, the tax would represent an increase in the cost of their insurance. A decision to seek less insurance will vary greatly with the employee's circumstances. These would include the amount of tax involved, a family member's health status, the nature of the reduced benefits in the lower premium plan, and the employee's degree of aversion to the financial risk of medical expenses.

The relative ease with which the employee could change to a lower premium plan is also of importance. In this regard, there are two situations to consider. The first is where a single group health plan is to apply without any choice of insurance plans available. The second is where there would be a legal requirement for an employer to offer at least two conventional insurance plans with different benefit levels. It is important to explore the impact of each situation:

(A) Employer maintains a single conventional insurance plan but includes HMO options when available.

Employers typically offer either a single company-wide insurance plan, or a single plan for all employees at a given location or in a specific bargaining unit. Since the HMO Act of 1973, qualified HMO options have been increasingly offered where available.

If the tax motivates some employees to desire a lower premium plan, they must secure the employer's agreement to change the plan for all employees. If the plan is under collective bargaining, union agreement would be needed as well. Before agreeing to a plan change for all employees, the employer must be convinced that most employees would willingly accept a plan with a higher, deductible or coinsurance or which covered fewer expenses. For most groups, such a change is unlikely.

Most people tend to be "risk averse" with regard to health care. The preference for high level health insurance protection reflects a desire to be relieved of financial risk and emotional pressure upon the occurrence of accident or sickness. It is doubtful that any significant proportion of employees will seek more out-of-pocket exposure to hospital and medical expense, or wish to have fewer services covered.

When people who do not have access to group coverage buy individual health insurance policies from insurance companies, the strong preference is for first dollar hospital and surgical plans. In 1981, the largest number of such persons, 12.7 million, were covered under basic hospital and surgical policies. Federal employees have available a choice of insurance plans, as well as a choice of alternate plans

(HMOs) in many areas. It has been observed that the plans with the highest level of benefits are by far the most popular in terms of enrollment. It has also been noted that medicare supplement insurance is widespread among persons covered by Medicare. In 1981, over 15 million persons age 65 and over had private hospital insurance protection and over 11 million had private surgical expense coverage. It is evident that the bulk of senior citizens tend to be risk averse.

The next most popular category was Comprehensive Major Medical, which covers both hospital and surgical out-of-hospital expenses. There were 3.7 million covered under this type of policy.

The least popular type of policy was Supplementary Major Medical, under which only 2.7 million were covered. This policy involves large deductibles ($500 to $2,500 and up) and is designed both for people with other base plan coverage and for those without other coverage who self-insure the large deductible amount.

Sales of these individual policies are to people who are spending after-tax income, and who have a broad selection of plans and carriers from which to choose. It seems that such people are strongly risk averse when it comes to hospital and surgical expense, and favor first dollar coverage.

It would be logical to expect that group-insured persons would also be risk averse, despite the presence of a new tax. This is especialy so since the tax, or additional employee "price," will normally be much less than what non-group insured persons pay for individual policies. There is little reason to believe, therefore, that any significant number of employees will seek less insurance as a result of the tax on employer contributions. Those who do are likely to be attracted only to plans that preserve hospital and surgical coverage at the expanse of vision, dental and other ambulatory care benefits.

In addition, an employer is not likely to change to a lower premium plan to satisfy a minority of employees. If collective bargaining is involved, the union leadership would face the same dilemma. A plan with more cost sharing might well be resented by employees who either are not liable for tax or who are being subsidized by other employees by the way the rules are written.

It seems more likely that employers would adopt a tax avoidance arrangement than change to a lower premium plan. This might avoid a plan change that would displease most employees, would solve the employee tax problem, and would avoid the administrative problems of the tax. The financial impact on the employer would be the same whether or not a change to a lower premium plan occurred. This is because under either approach the employer would reduce his contribution to the tax cap and pass the full reduction to employees in additional tax free or tax deferred benefits. Thus, whether or not many plans are changed, the treasury is not likely to realize much current revenue from this tax.

Overall, the risk averse nature of people and the difficult employee relations problems faced by employers are such that few groups are likely to change to lower premium insurance plans. From the HMO viewpoint, this should be a welcome development, since HMOs, with relatively higher premiums would have more difficulty competing against a company plan with more cost sharing.

(B) Employer offers a choice of two insurance plans as well as HMO options where available.

The legislation imposing the tax on employer contributions may also require employers to offer two insurance plans, one costing less than the other. The employer would probably be required to make the same contribution to each plan, and provide a rebate to an employee if the premium for his plan were less than the employer's contribution. Under this approach, any employee motivated by the tax to seek a lower premium plan could do so directly. This avoids the problems in changing a single plan that applies to all employees, and could result in more employees becoming covered under plans with more cost sharing features. The choice of plan process, itself, however, will produce severe distortions between the cost of the insurance plans, which will eventually make employee choice meaningless.

The risk averse nature of people described previously will initially limit the number of employees changing to lower premium plans, especially if significant cost sharing of hospital and surgical expense is involved. Those who do change, however, will be less likely as a class to need medical care in the near future than those who remain in the higher premium plan. This is because some of the employees who might be attracted to the lower premium plan will not change if future medical expenses are anticipated, which is known as adverse selection.

Adverse selection when a choice of plans is available, is a natural consequence of the tendency of employees to act in their own best interests when making their decisions. The degree to which it occurs depends upon the benefit differences of the two plans. Employees that anticipate large inpatient expenses for elective surgery in the near future will avoid a plan that requires more cost sharing of hospital and surgical expense. Employees with chronic illnesses, requiring frequent physician office visits and prescription drugs will avoid a plan with little or no out-of-hospital coverage. It is difficult to control adverse selection without severely limiting in various ways the employee's freedom to choose.

The subsequent effect of adverse selection will be a major distortion in the premiums required for the two insuance plans. At each annual opportunity to change plans, the rearrangement of employees by their medical needs will become more pronounced. The cost of the higher premium plan will increase much more rapidly than will the cost of the lower premium plan, which will force a revision in the way the employer's contribution is computed. If the contribution were linked to the high premium plan, the employer would soon be faced with much higher total contributions. This would be due to the rapidly increasing high premium plan costs, and the requirement to provide rebates to those in the lower premium plan. In order to control his cost, the employer would be likely to set his contribution each year in a manner unrelated to the specific premium for any plan. This would force larger and larger employee contributions under the high benefit plan, as the premium rose faster than the employer contribution.

As a result, even employees who would naturally desire the higher premium plan may feel compelled by high employee contributions to change to the lower premium plan. This could be disastrous for financially pressed lower paid employees who select the low premium plan, and then suffer the expenses of a major illness or accident. It is also a disaster for less healthy employees in the high premium plan, who pay ever increasing contributions for their coverage. The distortions produced in premium and employee contributions are such that employees will be less and less able to make rational choices with respect to price. The financial problems and employee discontent engendered would eventually either force a return to a single plan, or a narrowing of the difference in benefits between the two plans, or a cross-subsidization of the two plans' premium. The smaller the group involved, the faster the breakdown.

The requirement to offer two insurance plans would also mean much additional administrative expense for employers. The complications of permitting annual changes and providing rebates will drive up record keeping and electronic data processing expense. Many employers are likely to attempt to minimize this situation through tax avoidance arrangements. The effect on HMOs could be dramatic if employees could easily change to a low premium plan and even receive a rebate.

HMO premiums are normally in the range of high benefit plan premiums, so that HMOs would likely lose enrollment and suffer from adverse selection. Thus, the encouragement of the cost sharing strategy through employee choice could work against the HMO strategy for cost containment.

Overall, the tax together with a choice of plan requirement might temporarily result in more employees changing to low cost plans. Through the effects of adverse selection, however, the choice of plan structure would either be abandoned or the plan differences would be narrowed. Another solution might be to cross subsidize the two plans, but all of these outcomes are contrary to the original purpose of the two plans. The end result will be a few employees covered under low premium plans. The added burdens on employers will make tax avoidance arrangements even more attractive.

It was noted earlier that the link between the tax and better cost containment rests upon two theories. The first is that the tax will lead to a significant number of employees becoming insured under lower premium plans with more cost sharing. We have seen that this is not likely to result whether employers have a single plan or provide for employee choice. The second theory is that greater cost sharing will actually result in more cost containment for all patients. Let us consider the likelihood that this will occur.

Persons covered under plans with more cost sharing are expected, through their heightened cost sensitivity, to become more astute buyers of health care services. The average consumer, however, is not equipped to judge whether prescribed medical services are needed, or to shop hospitals and physicians for price value. Furthermore, most often the consumer would lack the emotional composure required to reach an informed decision. These are some of the reasons for the widespread consumer acceptance of comprehensive health insurance. When persons subject to more cost sharing avoid medical care, there may be longer range impacts on health status that are not presently well understood. More evidence needs to be accumulated to support the view that cost aware consumers can fulfill a marketplace role, without impairing their health in the process.

Under the theory, cost containment will be improved for all patients when hospitals and physicians respond to marketplace pressures and become more efficient and competitive. The marketplace pressures are to be produced by the persons covered under plans with greater cost sharing, who will utilize fewer services. Since, however, these persons are expected to be few in number, providers can simply increase fees. Most patients will remain covered by comprehensive insurance, and it will not be difficult to compensate for any income losses from patients with greater cost sharing plans. In addition, persons with more cost sharing on out-of-hospital benefits may seek hospital admission in order to have diagnostic tests covered. This could drive inpatient costs even higher. As long as these reactions are possible, the objective of cost containment through more cost sharing plans is not likely to be achieved. Competition between the traditional fee-for-service system and prepaid organizations such as HMOs may serve to control costs. A minority of persons with less insurance coverage, however, is not likely to induce much provider competition or cost containment.

In summary, the two theories underpinning the justification of the tax as a cost containment measure are not very plausible. Significant numbers of employees will probably not change to plans with more cost sharing. Those who do are not likely to produce the marketplace reactions from providers that will lend to cost containment for all patients. The impact of the tax on cost containment, therefore, is expected to be negligible, and possibly detrimental to the HMO strategy for cost containment.

REVIEW OF "TAX EXPENDITURES AND THE DEMAND FOR PRIVATE HEALTH INSURANCE" BY TAYLOR AND WILENSKY

A recent paper on taxing employers' contributions to group health insurance is entitled "Tax Expenditures and the Demand for Private Health Insurance" by Amy K. Taylor and Gail R. Wilensky. This paper provides estimates of the revenue to be gained by the federal and state governments. In addition, estimates are made of an anticipated reduction in health insurance premium. This is expected to occur as the tax motivates employees to seek reduced insurance, which, in turn, is to lead to better cost containment.

The authors identify the cost containment aspect of the tax as being of more importance than the revenue to be raised. The focus of the paper is on the expected changes in health insurance premiums. More public attention has been given, however, to the estimated amounts of revenue than the cost containment issue. The projections of revenue and reduced premium are based on several key assumptions, some of which are stated, while others are not mentioned. Since the assumptions are weak in various respects, the projections should be placed in proper perspective.

Revenue effects of the tax

The authors have used an estimate of $100.6 billion of group insurance premiums for 1983, of which $77 billion is attributed to employer contributions. These figures were obtained by a projection of data gathered in a 1977 National Medical Care Expenditure Survey. In view of the current and anticipated federal budget deficits, a new tax base of $77 billion must be considered attractive. If it all materialized as taxable income, the total increase in federal income tax is projected by the authors to be $20.443 billion. Additional revenues would also accrue to Social Security and to state governments through increased state income taxes.

It is assumed in the paper that the projected tax revenues would be the same regardless of the extent to which employees may change to lower premium plans. This is because if an employee changes to a lower premium plan, his or her other *taxable* compensation is expected to be increased to the extent that the employer's contribution is reduced. There is a second assumption mentioned at the end of the paper, the validity of which is essential if the revenue projections are to have any meaning whatever. This assumption is to the effect that employers and unions will *not* adopt tax avoidance arrangements, regardless of whether any plan changes occur at all. In our view, this assumption is difficult to justify.

The task of distributing $77 billion of employer contributions to employees as imputed income income will be extremely complex. It is virtually certain that the distribution will be inequitable by age, sex, and area of the country. Frequently, the tax will fall in haphazard and unpredictable ways. Tax avoidance arrangements could easily become common occurrences, under which sufficient employer contributions would be diverted into other tax free or tax deferred benefits, this relieving the employee's tax burden. It is clear that to the extent this occurs, the revenue projections in the paper could represent enormous overstatements in terms of current increased revenue.

In their study, the authors considered three levels of exemption, ranging from $1,125 to $2,400 per family. If the exemption amount were $1,800 per family and $720 per single individual, the total federal income tax increase expected in 1983 would be $3.454 billion, in the absence of any avoidance arrangements. Since the assumption that there will not be any such arrangements is unrealistic, the $3.454 billion estimate is likely to be grossly overstated. If three-quarters of employees become exempt, the increase in federal income tax would drop from $3.454 billion to $864 million. Most recently, a possible exemption of $2,100 per family and $840 per individual has been discussed. This would reduce expected revenue even further, and probably produce no more than $600 to $700 million in 1983 under the same assumptions.

Cost containment aspects of the tax

The authors appear to support the notion that tax free employer contributions have led employees to purchase more insurance than they would have, if they were using taxable income. The increased insurance levels are thought to have contributed to the rate of inflation in the health care sector. The theory is that the tax will lead to lower premium insurance plans with more employee cost sharing, and eventually more cost containment through marketplace competition. The paper deals only with projections of expected insurance premium reductions as a result of the tax. There is no discussion of whether greater cost sharing will actually result in cost containment for all patients, which is the theory many find implausible.

The question as to whether the proposed tax will result in a shift to less insurance is of great interest. An affirmative answer is essential if the tax is to be justified as step one in the quest for cost containment. The authors have calculated the expected reductions using an equation from economic theory, relating health insurance premium, employee income and the "price" to an employee for group insurance. In this context, the proposed tax will raise the "price" of group insurance for employees who are liable for any tax.

If there were no tax exemption amount, the authors predict that the tax would produce an aggregate reduction of $7.5 billion from the 1983 premium estimate of $101.6 billion. On a long range basis, the reduction is expected to grow to $16.7 billion. If various amounts of employer contribution remain tax free, the predicted reductions in premium are less. In the near term, a reduction of $3.6 billion would result if the exemption amounts were $1,800 family and $720 individual.

There is no discussion in the paper as to what proportion of employees would have the opportunity to change to a lower premium plan. Most employers provide only one plan of insurance to all employees, either company wide or at a specific location or bargaining unit. With the risk averse nature of people, few employees are expected to desire a change, and most employers will not change a plan for all to please a small minority. It may be that authors assumed that all employers would offer a choice of a high and low premium insurance plan. This would permit more employees to change intially. The adverse selection process, however, would so distort price that eventually the choice of plan approach would have to be either drastically modified or abandoned. The question of whether many single group plans will be changed, or whether there is a viable process for plan choice, must be addressed. Without evidence that a workable process for changing plans exist, we must be skeptical that the mathematical model is of value in predicting premium reductions.

It is well known that people tend to be risk averse when it comes to the financial hazard of accident and sickness, but how or whether this was taken into account by the authors is not clear. The equations seem only to consider premiums, employee income, and the employee's price of the plan. It would seem that the degree of benefit plan reduction would be of importance when forecasting reduced amount of premium. Some insight into the reasonableness of the forecasts may be gained by an inverse process.

In Table 3 of the paper, the short term reduction in premium is estimated at $3.6 billion when the tax exemption is $1,800 per family and $720 per individual. If we assume that 10 percent of employees make a change, the figure of $3.6 billion suggests that on the average, the lower premium plans represented a 36.0 percent premium reduction. A premium reduction of this magnitude would involve substantial benefit reductions, and it is arguable whether 10 percent of employees would make such a drastic change.

If it is assumed that 25 percent of employees make a change, the figure of $3.6 billion suggests that the average lower premium plan represented a 14.3 percent premium reduction. This premium reduction would involve less benefit reduction, but the attractiveness of the plan would depend on which benefits were reduced and to what extent. People tend to preserve a high level of hospital and surgical coverage, so that the reduced plan benefit design would be an important consideration. The average federal tax increase at this exemption level is estimated at only $147, and it may be questioned whether as many as 25 percent of employees would be willing to cut benefits 14.3 percent.

Since the projected premium reductions seem unrelated to the process of plan change, or the relationship between benefit design, premium reduction, and consumer attitudes toward risk, they are of limited value. There may be plausible internal consistency, in the projected reductions, but more analysis should be performed to establish the reasonableness of the results.

Chairman FORD. Mary Nell, let me thank you personally for appearing. We welcome you back. It is good to have you back as a witness.

STATEMENT OF MARY NELL LEHNHARD, VICE PRESIDENT, OFFICE OF GOVERNMENT RELATIONS, BLUE CROSS AND BLUE SHIELD ASSOCIATION

Ms. LEHNHARD. Thank you very much.

Mr. Chairman and members of the subcommittee, I am Mary Nell Lehnhard, vice president of the Blue Cross and Blue Shield Association. Our full statement has been submitted for the record, and, with your permission, I will summarize its contents.

Over the last several months, we have stressed several program elements that we believe are essential for an effective program to protect the unemployed. One concerns flexibility in overall program design and implementation.

Given the national scope of the problem, we believe a Federal initiative to assist the unemployed is entirely appropriate. However, we believe the Federal program should focus as much as possible on the development of locally defined programs. Problems related to unemployment manifest themselves differently among the States and within communities.

We are pleased that H.R. 3021 recognizes the needs of communities with high unemployment even though they may be in States where the overall unemployment rates are not high enough to otherwise qualify the State for Federal matching.

The second element relates to control on program costs. One of our primary concerns is the potential cost of a program to protect the unemployed. The experience with other entitlement programs has been that actual costs far exceed initial estimates.

We are concerned that H.R. 3021 does not fix a dollar maximum on the Federal contribution to individual State programs or provide any specific incentives for States to keep program costs down. We would urge you to consider some safeguards to avoid unexpectedly high program costs.

We also question whether the cost estimates of H.R. 3021 take into account the broad definition of "unemployed." As we read the bill, States could define the unemployed as persons who have weekly earnings of less than 30 times the minimum hourly wage rate.

Three focuses on private sector involvement. We support the broad role in H.R. 3021 for prepaid health plans, private insurance, and providers to work with their States to develop innovative approaches to insuring unemployed workers. A number of voluntary programs have already been developed by Blue Cross and Blue

Shield plans. We would hope that any Federal program would be flexible and encourage the further development of voluntary, collective efforts at the State and community levels.

Our fourth point relates to private sector requirements. We believe that any mandates related to employers providing protection for laid off workers should apply to all health plans.

We are concerned that H.R. 3021 does not apply the requirements on conversion from group to individual coverage to all employers. Employers who self-insure as well as multiemployer trusts, and health and welfare trusts, are excluded. This results in a competitive disadvantage for regulated insurers who must participate and leaves many employees unprotected.

H.R. 3183, introduced by Mr. Frenzel, does apply conversion requirements to both insured and uninsured group health plans, and we recommend adoption of its provisions on this point.

Five, sources of Federal financing. Finally, we would like to address our concerns about the source of Federal financing for this program. We urge you to oppose the administration's suggestion to use revenues gained from taxes on employer-paid health insurance to finance this program. We are convinced that this approach is ill-advised, for at least three reasons.

First, tax cap revenues would be an unpredictable, unreliable source of funds. If such taxes were to achieve their primary intent, to encourage employers to bring health benefits expenditures under the cap amount, the tax would not generate sufficient revenues to finance this or any other program.

Second, unless the level of the cap is regionally adjusted, which is administratively difficult, the tax burden would fall most heavily on the higher-cost areas of the country—which usually are those already suffering the highest levels of unemployment.

Third, we believe that creating a lid on employer-based health insurance spending may cause employers to cut their health benefits budget in two critical areas. Coverage for cost-effective preventive services and ambulatory care service coverage may be cut in favor of retaining maximum coverage for inpatient care.

Alternatively, employers may cut their benefit budgets by adding large front-end deductibles and copayments to the benefit package. This would place an especially heavy burden on the lower income worker who is least able to pay these cost-sharing amounts. It would also mean that aged, disabled and chronically ill workers could pay much more out-of-pocket because of their more frequent use of services.

Mr. Chairman and members of the subcommittee, I appreciate this opportunity to share our ideas and concerns with you.

Chairman FORD. Thank you very much.

[The prepared statement follows:]

STATEMENT OF THE BLUE CROSS AND BLUE SHIELD ASSOCIATION, PRESENTED BY MARY NELL LEHNHARD, VICE PRESIDENT

Mr. Chairman and Members of the Subcommittee on Health and the Subcommittee on Public Assistance and Unemployment Compensation, I am Mary Nell Lehnhard, Vice President of the Blue Cross and Blue Shield Association, the national coordinating agency for all Blue Cross and Blue Shield Plans. Today, Blue Cross and Blue Shield Plans serve more than 77 million members under private programs and an additional 26 million people under government programs. Many of our member

Plans have had a variety of experiences with the difficult problem addressed by today's hearing. On the basis of this experience, I will offer our views on some of the major issues involved in designing Federal legislation to provide health benefits to the unemployed and our specific comments on H.R. 3021.

Before I begin, I would like to commend the Subcommittees for addressing today's subject: health care benefits for the unemployed. For the unemployed who had Blue Cross and Blue Shield coverage, there have been opportunities to maintain their insurance coverage; all Blue Cross and Blue Shield Plans allow conversion from group policies to individual coverage for those who leave covered employment. In addition, most of our Plans hold periodic open enrollment during which anyone can buy coverage. The central issue, of course, is the ability of the unemployed to pay for their health care coverage. The availability of coverage isn't worth very much if a person cannot afford to pay the premiums. H.R. 3021 would provide some Federal financial assistance to the States to help address this problem directly.

Over the last several months, as this issue has been considered by the Congress, we have stressed several program elements that we believe are essential to the establishment of an effective and efficient program to protect the unemployed:

(1) Flexibility in overall program design and implementation;
(2) Control on program costs;
(3) Opportunities for private sector involvement;
(4) Equitable requirements governing private sector participation; and
(5) Reliable and appropriate sources of Federal funds.

We are pleased that many of these elements are reflected in H.R. 3021 and other bills that have been developed. In discussing each of these program elements in further detail, we will comment specifically on relevant provisions of H.R. 3021.

FLEXIBILITY IN OVERALL PROGRAM DESIGN AND IMPLEMENTATION

Given the national scope of the problem, we believe a Federal initiative to insure the unemployed is entirely appropriate. However, while unemployment is a national problem, it appears to manifest itself differently in every State and even among communities within States. Therefore, we believe the Federal initiative should serve to stimulate and assist development of locally defined programs.

The program outlined in H.R. 3021 provides Federal funding to States that demonstrate, by preparation of an acceptable plan, intent to meet basic program design requirements regarding administration, benefit coverage, eligibility, and private sector participation.

We are pleased to see that H.R. 3021 recognizes the legitimate needs of certain communities with high unemployment rates that are located in States with overall unemployment levels below the qualifying cutoff for this program. By allowing States to extend this program to these communities, the legislation provides assistance where the need is greatest.

Regarding benefit design, we would like to point out that Blue Cross and Blue Shield Plans that have begun to consider programs to insure temporarily unemployed workers have determined that the benefit package must cover limited, nonelective inpatient and outpatient care. Generally, Plans suggest offering 9 to 15 inpatient days and 5 to 10 outpatient visits, including emergency room care. And, as H.R. 3021 provides, we believe prenatal, delivery and postpartum care should be covered.

Another important element in benefit design is the amount of enrollee cost-sharing that will be required. We recognize that if public funds are to be stretched as far as possible, some form of cost-sharing is probably necessary. The critical question is, just how much cost-sharing can an unemployed person absorb? The dollar value of even modest premiums, deductibles and copayments may be excessive for someone long out of work.

H.R. 3021 requires States to impose limited premiums on enrollees. A subtle aspect of this form of cost-sharing in a program like this is that it tends to encourage participation by people who expect to use services and discourage participation by low utilizers. This is the problem of "adverse selection", and it results in per enrollee costs being higher than they would be if a cross-section of the unemployed will remain unprotected, whatever program is offered, as long as a premium is charged.

CONTROL ON PROGRAM COSTS

One of our primary concerns is the potential cost of a program to insure the unemployed. In the absence of more information on the number of people who do not have access to health insurance coverage because of unemployment, it is especially difficult to forecast the expected cost of the program outlined in H.R. 3021. The experience with other entitlement programs has been that actual costs far exceed those estimated by experts when the programs were being considered. The actual costs of a Federal/State program to protect the unemployed will depend on the number of eligible persons who enroll, their utilization and State efforts to contain program costs.

Enrollment and eligibility.—The Congressional Budget Office (CBO) estimates that about 19.1 million individuals would be eligible in 1984 for participation in the Federal/State program established by H.R. 3021. The CBO appropriately assumes that not all of those eligible for participation will actually enroll. However, it is unclear whether the CBO estimates have taken into account the broad definition of unemployed authorized by H.R. 3021. Under section 2102(c)(4) of the bill, States could include as "unemployed", persons who are working if their weekly earnings are less than 30 times the minimum hourly wage rate.

Utilization.—Utilization is difficult to predict. In our experience, utilization of unemployed group subscribers on extended coverage tends to be about 130 percent of average group utilization. As a result, Plans have been closely examining benefit designs which offer adequate, but limited, coverage. We believe the benefit design suggested in the proposed bill offers a reasonable scope of service coverage without establishing opportunities for excessive elective utilization. As noted earlier, this benefit design is consistent with that which is now being offered by a number of Blue Cross and Blue Shield Plans. However, because of the difficulty of predicting utilization of services, total program costs may be higher than currently estimated.

Cost containment.—The State and Federal matching payment arrangements set forth in the bill appear to be a reasonable method of financing State programs. We do, however, have one concern that we would like to share with you. The matching payment schedule does not fix a dollar maximum to the Federal contribution, which raises the question of whether States would have sufficient incentives to keep total program costs down. We would urge you to conserve establishing financial limits or incentives for efficient performance before enactment of this program to avoid unexpectedly high or uncontrollable costs. This problem can be addressed effectively through a block grant as well as through revisions to the matching payment approach.

OPPORTUNITIES FOR PRIVATE SECTOR INVOLVEMENT

H.R. 3021 provides ample opportunity for prepaid health plans, private insurance, providers and provider groups to work with their States to develop innovative approaches to insuring unemployed workers. These opportunities range from the provision of administrative services to the assumption of the underwriting risk for those individuals. We applaud this recognition of existing and potential private sector initiatives.

A number of voluntary initiatives are already being made by some Blue Cross and Blue Shield Plans. Several Plans located in States with especially high unemployment rates have looked at new approaches to offering coverage to the unemployed.

To enable them to offer fairly comprehensive coverage at affordable premiums, those Plans have begun to develop voluntary cooperative relationships with providers and physicians in their areas. The Western Pennsylvania Blue Cross Plan, working with Pennsylvania Blue Shield, for example, has arranged a special program in which participating physicians and hospitals forgive cost-sharing amounts. In addition, the Plan subsidizes premium payments. Through this cooperative undertaking, premiums for a limited family coverage are being offered to unemployed workers for about $60 per month.

An interesting program is also underway in Charleston, West Virginia. The Charleston Blue Cross and Blue Shield Plan developed a limited hospital benefit for the United Mine Workers union. The benefit was originally designed to protect workers during the UMW strike. The union, pleased with the security offered by the benefit, asked the Charleston Plan and other Plans that administer this account to make this coverage available to miners who have exhausted their health and welfare benefits due to layoffs. It now appears that other unions are looking into this benefit concept. As an impressive footnote, the Charleston Plan has had a number of calls from local charitable organizations volunteering to help union members pay the minimal monthly premiums.

In Southwestern Virginia, the Blue Cross and Blue Shield Plan has recently announced a program called Term Reserve. It provides outpatient and inpatient hospital and physician services for a twelve-month benefit period. Each person would be protected for up to $1 million against the cost of catastrophic illness or injury. The premium for this coverage is about $77 per month for a family, $50 for an individual with a dependent child, and $33 for an individual.

In many parts of the country, physician organizations, community groups and health care providers have rallied to assist the unemployed worker secure necessary care. We do not doubt that legislative assistance would greatly help communities where such volunteerism does not now exist. However, it would be unfortunate if the availability of such assistance failed to recognize and support volunteer and private market efforts.

PRIVATE SECTOR REQUIREMENTS

Under H.R. 3021, employers would be required to provide opportunities for employees to revise their coverage to include laid-off spouses and to provide continuation of coverage to laid-off or separated workers for at least 90 days. We are pleased that H.R. 3021 makes these provisions applicable to all employers subject to minimum wage requirements of the Fair Labor Standards Act of 1938. In so doing, the legislation incorporates the many large employers who are now self-insured and who might not otherwise be subject to this provision, because of Federal preemption (under ERISA) of State laws dealing with employee benefit plans.

We are concerned, however, that H.R. 3021 does not apply the requirements concerning conversion from group to individual coverage to all employers. This approach would result in a competitive disadvantage for those must participate and, thereby promote the further development of a self-insured approach to providing health benefits. H.R. 3183, introduced by Mr. Frenzel, does apply conversion requirements to both insured and uninsured group health plans and we recommended adoption of its provisons on this point.

SOURCES OF FEDERAL FINANCING

Finally, we would like to address our concerns about the source of Federal financing for this program. We would urge the Subcommittees of oppose the Administration's suggestion to use revenues gained from taxes on employer-paid health insurance to finance this program. We are convinced that this approach is ill-advised for at least three reasons.

First, tax cap revenues would be an unpredictable, unreliable source of funds. If such taxes were to achieve their primary intent, to encourage employers to build more cost-sharing into their benefit packages to bring expenditures under the cap amount, the tax will not generate sufficient revenues to finance this or any other program.

Second, unless the level of the cap is regionally adjusted, which is administratively difficult, the tax burden would fall most heavily on the higher-cost areas of the country—which usually are those already suffering the highest levels of unemployment. Moreover, in any region of the country, employers that offer good continuation coverage for laid-off workers will be discouraged from doing so, for the cost of such continuation coverage is usually built into the rates for the regular group policy.

Third, we believe that creating a lid on employed-based health insurance spending may cause employers to cut their health benefits budget in two critical areas (and probably shift their costs to other non-taxed fringe benefits). Coverage for preventive services and ambulatory care services may be cut in favor of retaining maximum coverage for inpatient care. People will be encouraged to seek inpatient care when outpatient service would have been equally as effective and must more cost-efficient. Alternatively, employers may cut their benefit budgets by adding large front-end deductibles and copayments to the benefit package. This action will place an especially heavy burden on the lower-income worker who is least able to pay these cost-sharing amounts or to independently purchase coverage to protect against their occurrence.

We do not presume to tell you what the best source of Federal revenues for this program would be, but we think we know what the worst source would be—a tax on employee health benefits.

Chairman Jacobs, Chairman Ford, and Members of the Subcommittees, I appreciate this opportunity to share our ideas and concerns with you. I encourage you to consider our suggestions and to call on us if we can be of assistance to you or your staffs in this important policy development process.

Chairman FORD. Mr. Krauskopf, the Chair recognizes you at this time.

STATEMENT OF JAMES A. KRAUSKOPF, COMMISSIONER, HUMAN RESOURCES ADMINISTRATION, NEW YORK CITY

Mr. **Krauskopf**. Thank you, Mr. Chairman, Mr. Moore. I appreciate the opportunity to testify today on this important issue.

At this point, no one can question the dire need for a Federal program of health insurance for the unemployed. The economic recession has left an estimated 11.3 million people in this country without jobs. In New York City alone there are 270,000 unemployed workers, approximately 120,000 of whom are receiving unemployment compensation. Most of these jobless workers have lost health insurance coverage for themselves and their dependents with the loss of their jobs.

In addition to those currently receiving unemployment benefits, there are thousands of jobless New Yorkers who exhaust their unemployment benefits each month. For example, in February 1983, 8,400 unemployment compensation beneficiaries received their last unemployment check.

The unemployed—those who are currently receiving benefits and those who have exhausted their benefits—have little protection from the high costs of medical care. Unemployment benefits, which average $103 a week in New York State—and, by the way, there is a move in the New York State Legislature to raise that level—are far too low to permit jobless workers to finance the purchase of private health insurance.

Yet, many of the unemployed have assets such as cars, furnishings and life insurance policies which make them ineligible for health care through the Federal medicaid program, despite their low income. To qualify for medicaid benefits, these individuals would have to impoverish themselves by expending a substantial portion of these resources on medical care.

Since only a small portion of the unemployed are able to qualify for existing Federal benefits, the cost of providing health care to them has fallen directly on localities and, to some extent, on the States. Localities such as New York City, which have municipal hospital systems, provide free medical care to the unemployed through their hospital facilities. This cost is borne by the city's taxpayers.

Those that come to the city's public hospitals for treatment represent only a portion of the unemployed. Many may not be aware of the availability of free treatment, and others may be reluctant to come forward unless they are confronted with a life-threatening situation because they cannot pay. They don't come in at a time when preventive care might head off more costly hospitalization.

A number of the hospitals in the city have experienced a growth in the number of self-pay patients, reflecting an increase in the number of people who have no health insurance. The city has shouldered the cost of providing health care through the medicaid program to the rapidly rising home relief caseload—the general assistance program, as it is known in other places around the country.

We have had quite a dramatic increase in the last year in home relief. Just giving you the year-to-year comparisons from March 1982 to 1983, there has been an increase of 117,00 to 145,000 people.

No Federal participation is available for the medicaid costs of home relief adults. Thus, the health care costs of this growing population are paid for by State and city dollars.

In addition, many of the jobless workers, who have been able to provide for themselves and their families without turning to public assistance, have had to rely on medicaid when confronted by a serious illness. The growing number of unemployed persons has been a primary factor in our approximately 17-percent increase in the number of medically needy recipients in the city over the last year. These are families and individuals whose income or assets are above the Federal guidelines. They only become eligible for medicaid after spending a substantial portion of their resources on medical care.

We were pleased to see that this week the Senate adopted an amendment offered by Senator Moynihan for health insurance for the unemployed to add $225 million to the supplemental appropriation for fiscal year 1983. Congress must now enact a Federal program to provide health protection for these jobless workers and to provide some fiscal assistance to the States and localities, which have been forced to absorb the costs of health care for this population.

We recognize that designing an effective program of health insurance for this population is difficult for several reasons. First, there is no way to accurately predict the demand for the program and, hence, the potential cost. In addition, there are numerous approaches that can be taken with regard to eligibility, covered services, funding and other issues, each of which has different costs and benefits.

We generally support H.R. 3021 offered by Congressman Waxman, but there are certain recommendations we would like to make. Regarding eligibility, we strongly support the coverage under this program for both individuals and their families currently receiving unemployment benefits and those who have exhausted their benefits during the past 2 years. We must deal with the reality that many people have used up their unemployment benefits, therefore the program must cover some retroactive period. We believe it is appropriate to include people who have exhausted their unemployment benefits within the last 2 years.

In recognition of the limited resources likely to be available for this program, we also would favor a provision suggested by Representative Rangel in his recent proposal that would require coverage of families with children living below the poverty line but give States the option of imposing some type of income and asset requirements. This would allow States to target funds to those whose resources prevent them from qualifying for medicaid, but whose income is insufficient to provide for their medical care.

The provision of health insurance to these families and individuals would mean that they need not impoverish themselves by spending down to the medicaid level.

We are also concerned that all the proposals provide only for voluntary participation for those who are eligible. In localities like New York City, where, as I mentioned before, there is a municipal hospital system and free medical care provided, States should be given the option of making participation for all eligible persons mandatory. Otherwise, in these areas, the unemployed would have little incentive to participate voluntarily, especially if the program included premiums or copayments or other kinds of cost sharing.

Therefore, we feel that it is important that if we are going to avoid having local governments continue to bear all the costs, as they do now through municipal hospitals, that those people who are eligible for this new protection should be required to enroll in it.

Regarding copayments, deductibles and premiums, the city believes that if premiums are imposed, they should be set at a level that is low enough so as not to discourage participation. We are trying to encourage preventive care through this kind of program to head off more costly medical expenses later, therefore the premiums should not be set so high that people would not enroll, and therefore not get that preventive care.

Similarly, States should not be required to impose copayments or deductibles. The unemployed can hardly be expected to set aside money from their small unemployment checks, so that when faced with an illness they have adequate resources to pay a copayment or deductible.

For example, we are concerned that the option given under Representative Rangel's program to impose cost-sharing requirements up to $600 a year might substantially burden the unemployed and, therefore, defeat the purpose of the program.

We also have some concerns about the administrative aspects of copayments. We know that they would be difficult to collect. They might lead to more bad debt at the municipal hospitals and might also discourage participation of some private physicians and others who would not want to participate in a program where they had responsibility to collect the copayments.

With regard to coverage of services, we would emphasize the preventive services. I heard Mr. Stockman this morning, and I recall that he seemed to go the other way on this and recommended a catastrophic program rather than preventive services.

I think what is most important is to make sure preventive services are provided so that the catastrophic costs only occur when they can't be avoided. Therefore, the coverage should include such services as outpatient treatment, emergency care, rural health care, clinic and physician services, family planning, midwife services, and laboratory and X-ray services.

We would also support a limited program for inpatient hospitalization. We would recommend that rather than the 9-day limit in the Waxman bill, that the limit be 10½ days, which seems to be more realistic given our actual experience in the city hospitals. But, again, I would stress that we would emphasize the preventive care and not the catastrophic care as being most important. And, in the long run, it would reduce costs.

We are also opposed to provisions that were added to the Waxman bill that would prohibit the use of any funds under the program for abortions, especially in light of the recent Supreme Court decisions. We feel that the individual's right to an abortion should be continued and protected.

The city strongly supports the provisions in the Waxman bill that would establish a 4-year program for direct financial assistance to municipal hospitals. There are many cities, in addition to New York, where there are hospitals that have been caring for a disproportionate number of low income people who have lost jobs and, as a result, lost their health coverage. We urge that some provisions be made for reimbursing localities for those costs.

We generally support the provisions of the Waxman bill regarding the Federal matching in the legislation. We estimate that it would provide about 90.9 percent Federal share in New York. We recommend, however, that a provision be added that would require States to take into account the relative unemployment among its municipalities in allocating the funds within the State.

Finally, we question the use of premiums, copayments, and deductibles as the source of administrative funds for the program. We don't think that is an appropriate way to fund the administrative costs. Rather, they ought to be funded as in other programs, along with the basic costs of operating the program.

In conclusion, we would just like to commend the committee for focusing attention on what is a critical problem, and I hope there will be speedy action on enacting legislation to provide health insurance for the unemployed.

Thank you.

Chairman FORD. Thank you.

[The prepared statement follows:]

STATEMENT OF JAMES A. KRAUSKOPF, COMMISSIONER, HUMAN RESOURCES ADMINISTRATION, NEW YORK CITY

Mr. Chairmen, I am Jack Krauskopf, Commissioner of the Human Resources Administration in New York City. Thank you for the opportunity to appear at this joint hearing today in support of providing health insurance for jobless workers and their families.

At this point on one can question the dire need for a federal program of health insurance for the unemployed; the economic recession has left an estimated 11.3 million people in this country without jobs. In New York City alone there are 270,000 unemployed workers, 120,000 of whom are receiving unemployment compensation. Most of these jobless workers have lost health insurance coverage for themselves and their dependents with their jobs. In addition to those currently receiving unemployment benefits, there are thousands of jobless New Yorkers who exhaust their unemployment benefits each month. For example, in February 1983, 8,400 unemployment compensation beneficiaries received their last unemployment check.

The unemployed—those who are currently receiving benefits and those who have exhausted their benefits—have little protection from the high costs of medical care. Unemployment benefits, which average $103 a week in New York State, are far to low to permit jobless workers to finance the purchase of private health insurance. Yet, many of the unemployed have assets such as cars, furnishings and life insurance policies which make them ineligible for health care through the federal Medicaid program despite their low income. To qualify for Medicaid benefits, these individuals would have to impoverish themselves by expending a substantial portion of these resources on medical care.

Since only a small portion of the unemployed are able to qualify for existing federal benefits, the cost of providing health care to them has fallen directly on localities and, to some extent, on the states. Localities such as New York City, which have municipal hospital systems, provide free medical care to the unemployed through their hospital facilities. This cost is borne by the City's taxpayers.

Those that come to the City's public hospitals for treatment represent only a portion of the unemployed. Many may not be aware of the availability of free treatment and others may be reluctant to come forward unless they are confronted with a life threatening situation because they cannot pay.

A number of the hospitals in the City have experienced a growth in the number of self-pay patients, reflecting an increase in the number of people who have no health insurance. At the Bronx Municipal Hospital Center alone, the number of uncovered in-patient days rose by 3,000 and the number of uncovered ambulatory care visits rose by 5,000 over the last two years. New York City's Health and Hospital Corporation is witnessing more and more of what they view as "patient dumping;" that is, an increase of self-pay patients who are now being turned away from the voluntary institutions because of their loss of health insurance.

The City has also shouldered the cost of providing health care through the Medicaid program to the rapidly rising Home Relief caseload. The number of people forced by the current economic conditions to depend on Home Relief, the State's general assistance program, rose from 117,000 in March 1982 to over 145,000 in March 1983. No federal participation is available for the Medicaid costs of Home Relief adults. Thus, the health care costs of this growing population are paid for by State and City dollars.

In addition, many of the jobless workers, who have been able to provide for themselves and their families without turning to public assistance, have had to rely on Medicaid when confronted by a serious illness. The growing number of unemployed persons has been a primary factor in our approximately 17 percent increase in the number of medically needy recipients in the City over the last year. These are families and individuals whose income or assets are above the federal guidelines. They only become eligible for Medicaid after spending a substantial portion of their resources on medical care.

We understand that just this week the Senate adopted an amendment offered by Senator Moynihan for health insurance for the unemployed to add $225 million to the supplemental appropriation for fiscal year 1983. Congress must now enact a federal program to provide health protection for these jobless workers and to provide some fiscal assistance to the states and localities, which have been forced to absorb the costs of health care for this population.

We recognize that designing an effective program of health insurance for this population is difficult for several reasons. First, there is no way to accurately predict the demand for the program and hence the potential cost. In addition, there are numerous approaches that can be taken with regard to eligibility, covered services, funding, and other issues, each of which has different costs and benefits.

While we support H.R. 3021 offered by Congressman Waxman, we would like to use this opportunity today to make a number of recommendations on issues which New York City believes should be addressed in any federal program of health insurance for the unemployed.

ELIGIBILITY

New York City strongly supports coverage under this program for both individuals and their families who are currently receiving unemployment benefits and those who have exhausted their unemployment benefits during the two years prior to the implementation of the program. However, in recognition of the limited resources available for this purpose we favor Rep. Rangel's proposal to require coverages of families with children living below the poverty line and to give states the option of imposing some type of income and assets requirements. This would permit states to target funds to those whose resources prevent them from qualifying for Medicaid, but whose income is insufficient to provide for their medical care. The provision of health insurance to these families and individuals would mean that they need not impoverish themselves by spending down to the Medicaid level to get medical care. In the long run, the spend down approach is detrimental to both the individual and the government, since it may result in forcing families onto public assistance.

MANDATORY PARTICIPATION

In localities such as New York City where free medical care is available through a municipal hospital system, states should be given the option of making participation for all eligible persons mandatory. In such areas, the unemployed would have little incentive to participate voluntarily in the program, since medical care is already available to them at these facilities free of charge. There would be even less incentive to participate if substantial premiums are imposed. Thus, voluntary participation would deprive localities like New York of needed fiscal relief.

CO-PAYMENTS, DEDUCTIBLES, PREMIUMS

New York City believes that if premiums are imposed, they should be set at a level that is low enough so as not to discourage participation. States should be given the option of imposing premiums, but in no case should they be set at a level which would impose a hardship on the unemployed. Unemployment benefits in New York

State are already among the lowest in the nation. The unemployed, many of whom already have had to adjust to a substantially lower standard of living, can ill afford even a nominal deduction from their benefit check on a regular basis.

Similarly, states should not be required to impose co-payments or deductibles. The unemployed can hardly be expected to set aside money from their small unemployment checks, so that when faced with an illness they have adequate resources to pay a co-payment or deductible. For example, the option given states under Rep. Rangel's proposal to impose cost-sharing requirements up to $600 a year would place a substantial burden on the unemployed. These cost-sharing requirements would only discourage participants from seeking necessary medical care for themselves and their families, thus defeating the purpose of the program.

Moreover, such co-payments would be very difficult to collect. Any uncollectible co-payments in the municipal hospital system would result in a direct increase in the amount of bad debt incurred by the City. This would have to be made up entirely with City Tax Levy funds.

In addition, the imposition of co-payments on unemployed people who are unable to afford them would also have an adverse affect on the willingness of physicians and others to participate in this program. As a result, the participants would be forced to seek more expensive forms of care at out-patient hospital facilities or emergency rooms.

COVERED SERVICES

The City recommends that coverage under a program of health insurance for the unemployed include basic preventive services and limited in-patient hospital care. Given the limited amount of resources which are expected to be allocated to this program, each extension in the range of services covered must be considered in terms of the corresponding reduction in the number of people who can be served by the program.

The City recommends that the range of preventive services covered by the program include: out-patient hospital, emergency, rural health, clinic and physician services (up to 10 visits a year); laboratory and X-ray services; and family planning, nurse-midwife services. In addition, the program should provide coverage for a limited number of in-patient hospital days. However, we believe that the 9 day limit under the Waxman bill is inadequate and should be extended. In New York City the average length of stay at HHC facilities is 10.5 days. If the restriction on the number of covered days is not set at a realistic level, City Tax Levy funds would have to be used to cover the cost of additional days.

Overall, the primary emphasis of the program should be on preventive care rather than catstrophic care. Those individuals whose illnesses are serious enough to require extended in-patient hospital care will, in all likelihood, become Medicaid eligible. Since they have no insurance these people will be forced to spend a significant portion of their resources on medical care. Once they have "spent down" to the Medicaid level they will become eligible for Medicaid benefits.

In particular, we view the provision of primary and preventive care as essential, not only in maintaining wellness, but in controlling health care costs. There is no doubt that inability to pay is a deterrent to seeking health care. As was seen in the elderly population prior to the availability of Medicare, those persons who are without coverage wait until they are absolutely too ill to avoid health care services any longer. As a result, there is a marked increase in the number of acute care hospital days.

FUNDING FOR ABORTION

We oppose the provision added to the Waxman bill, which prohibits the use of any funds under this program for abortions. It is inappropriate to restrict the use of these funds for abortions, especially in light of the Supreme Court's action this week reaffirming an individual's constitutional right to an abortion.

FUNDING FOR MUNICIPAL HOSPITALS

The City strongly supports the provision in Rep. Waxman's bill to establish a four year program to provide direct financial assistance to municipal hospitals to help them serve unemployed and other non-paying patients. Municipal hospitals, such as those in New York City, which provide free care to a disproportionate number of low-income patients should be guaranteed funding under this provision. These hospitals are already overburdened with the cost of providing health care to those who are impoverished or unemployed as a result of the national recession. Funding under this provision should be targeted to these facilities to help relieve the fiscal burden they are placing on local governments.

PROGRAM FUNDING

Under a federal program of health insurance for the unemployed, responsibility for providing medical care to the unemployed would be transferred from the states and localities to the federal government. We assume that Congress clearly intends that the funds made available under this program be used to offset the cost incurred by the City in providing free medical care to unemployed individuals at municipal hospitals or through locally financed public assistance programs.

We support Rep. Waxman's bill which would provide states and localities with substantial federal matching funds to implement and administer a program of health insurance for the unemployed. Under H.R. 3021, New York State's federal share would be 90.9 percent. State and local governments and cost-sharing provisions would be responsible for the remaining 9.1 percent.

States should not be required to generate the non-federal share of program costs exclusively through premiums, co-payments and deductibles unless nominal premiums could produce sufficient revenue.

We oppose Rep. Rangel's proposal to use the mandatory 2 percent premium to fund administrative costs. Rather we recommend that the administrative expenditures of all agencies involved in running the program, not just the unemployment offices, be funded entirely by federal funds.

In allocating federal funds among the states the City recommends that the formula be developed in a way to target funds to localities within states which have unemployment rates above the overall state level. In this way funds will be targeted directly to those areas which are suffering most severely from the effects of high unemployment.

In conclusion I would like to reiterate the strong support of the City of New York for a federal program of health insurance for the unemployed. We urge the Congress to act quickly so that the unemployed, who through no fault of their own have fallen victim to the recession, can begin to receive the health protection they deserve. In New York City, our public hospitals are open to all who are in need. We urge that the Federal program be designed to provide financial assistance to places like New York where the local taxpayers are already bearing too much of these costs.

Chairman **Ford**. Mary Nell, the Blue Cross/Blue Shield testified before the Senate on S. 951. What is your position as it relates to the two bills—the one we have now, H.R. 3021, and Senate bill 951?

Ms. **Lehnhard**. I am sorry. I didn't hear——

Chairman **Ford**. S. 951. I have testimony before me that the Blue Cross/Blue Shield testified before the Senate Finance Committee.

Ms. **Lehnhard**. You mean our relative position on the two?

Chairman **Ford**. Yes; the difference in the two. I am not sure the Senate bill is the same as the bill Congressman Rangel is talking about. I think there is a difference between the two.

What is the position as it relates to the House bill before us now, and the Senate bill 951?

Ms. **Lehnhard**. The Senate bill, Senator Dole's bill, uses the medicaid mechanism, but also has flexibility for the States to administer it as they want.

I think, generally, in comparing the two bills and all the bills under consideration, the more flexibility that is given the State, the more we would support it. Mr. Waxman's bill seems to have a great deal of flexibility, even though he approaches it initially through the medicaid provision.

Mr. Rangel's bill, of course, starts with a block grant program, which gives a great deal of discretion to the States.

One other aspect of Mr. Rangel's bill we would tend to support would be the cap on Federal expenditures. As I mentioned, one of the concerns we have is that even though some of the bills are limited in eligibility, duration and scope of benefits, there is still an open-ended entitlement program. Given that we are not sure what the extent of the problem out there is, we are concerned about a program which exceeds the best estimates that we make right now.

Chairman **Ford**. Thank you

Mr. Moore.

Mr. **Moore**. Thank you, Mr. Chairman.

Mr. Dorsch, on pages 9 and 10 as well as 11, you give a good indepth discussion on your part as to the opposition of a tax cap.

My question is, the fact that it appears that there is one additional reason that is missing. That probably is not part of the reason you are opposing this, but is it not a fact if there was a tax cap, if there was a reduction in the amount of insurance being bought by employers on behalf of employees over the $2,100 amount, if that did happen, there would likewise be a reduction in revenue being paid in premiums and a reduction in the amount paid to your member companies; is that correct?

Mr. **Dorsch**. That is in fact a possibility, but it is a very minor consideration.

I will tell you very candidly, Mr. Moore, that if our companies thought that the tax cap as proposed, at higher or lower levels, would significantly control rising hospital costs, we would be the first in line to be for it.

We have been second to no one since the late 1970's, when health cost containment was again before this committee and before the Congress. We have been out in front ever since, taking a hard line for hospital cost containment because our industry's ax is getting gored as bad as anybody else is, both because of the cost shifting problems generated by the medicare program and the fact that we cannot keep our premiums up with rising claim costs.

I will point out, too, that a large portion of the business today, maybe more than a third to a half, is self-insurance.

There are conflicting arguments given by those in favor of the cap. However, you can't have it both ways, as indicated by the Blue Cross testimony.

You can't raise revenue because all these benefit plans are going to be over the cap, and on the other hand, contain costs, because people are going to buy a lot of less insurance.

Our own view is, quite frankly, that there is not going to be a significant cutback of insurance, particularly not in hospital insurance. We think that people are sufficiently frightened now, that they are terrified of rising hospital costs and are going to keep up their insurance.

We could be wrong.

Mr. **Moore**. I have no interest in raising revenue. I believe this happens to be, from the arguments I have seen, something that may help us because people will demand less insurance and therefore the cap will be somewhat of a stabilizing force on the cost of health care.

I care not about raising revenue, but people say it will.

Mr. **Dorsch**. Of all the people in the private sector, all the major groups, everybody who is on our side of the cash flow, on the Government's side of the cash flow, from the users to the providers, that is, the employers, the unions, the insurance companies, Blue

Cross, senior citizens, all agree this will not contain health care costs.

The only witnesses you have gotten from the private sector today that say it will contain health care costs are the hospitals and the doctors. I am reminded of, and perhaps you remember reading the stories that came out of the great southland by Joel Chandler Harris about Br'er Rabbit and when he got caught by the fox and bear, he says, you know, "hang me from the highest tree, boil me in oil, do what you will, but please don't throw me in the briar patch."

Well, if you are talking about cutting the cash flow to the hospitals and the hospitals are telling you, oh, yes, this will work, this is good policy, that will cut our cash flow, I would be suspicious.

Mr. MOORE. As I indicated, too, this causes me to be somewhat suspicious of your testimony if it cuts cash flow to your companies.

Mr. DORSCH. That is right, sir. Look at our record on hospital cost containment.

Mr. MOORE. There are people besides those you have heard who do say it will help reduce costs. That is why I have an interest in it.

One additional point: Mr. Dorsch has asked to have a white paper introduced into the record. I think that is quite proper.

Mr. Chairman, I would like to ask that an answer to the white paper prepared by the American Enterprise Institute be allowed to be submitted into the record.

Chairman FORD. It will be.

[The information follows:]

AMERICAN ENTERPRISE INSTITUTE FOR PUBLIC POLICY RESEARCH,
Washington, D.C., May 26, 1983.

Hon. W. HENSON MOORE,
House of Representatives,
Washington, D.C.

DEAR CONGRESSMAN MOORE: The Health Insurance Association of America (HIAA) has recently released a paper criticizing the cap proposed by the President on the amount of employer contributions to health insurance that employees may exclude from their federal taxable income. We are a group of independent health economists who believe that this proposal should be a crucial and indispensable part of needed reform in federal health care policy. The HIAA pamphlet opposing the tax cap, entitled "Health Care Tax—A Critical View," requires a prompt rebuttal to set the record straight.

In our view, Congress should enact legislation that places a limit on the tax-free nature of employer contributions to health insurance. This step would not only constitute sensible health care policy, but also reflect fair social policy and sound tax policy.

I. THE TAX CAP—A NO-LOSE PROPOSITION

The tax subsidy ceiling is one of those rare policy choices that produces socially desirable benefits regardless of which of its possible effects occur. To the extent that it induces more cost-consciousness in the amount and type of insurance coverage which people choose, it will reduce health care expenditures and prices. To the extent that people choose to continue purchasing comprehensive first-dollar coverage, there will be a clear indication that this is the type of coverage people want and the implicit assurance that they are willing to tolerate the associated high price of comprehensive insurance coverage. In either case, there should be a substantial increase in federal tax revenues.

Perhaps most important, the tax cap will help correct a glaring inequity: the uncapped exclusion of employer-paid health insurance from taxable employee pay subsidizes middle and upper-income households without limit while government policy subsidizes only a portion of lower-income households in an increasingly restrictive fashion. According to a study conducted by the National Center for Health Services Research (NCHSR), the present exclusion is worth $83 per year to a family with an annual income of $10,000 to $15,000, but $622 to a family with an annual income of $50,000 to $100,000. Even worse, uninsured, unemployed people get no tax subsidy at all; yet, many of these people are ineligible for Medicaid.

II. REVENUE EFFECTS

The proposed tax subsidy cap is projected to raise about $2.3 billion in federal income taxes:

There may be some debate about the precise behavioral responses to the tax cap. We believe that it will lead to more choice of health plans for employees, stimulate the growth of cost-effective health plans, and raise federal revenues. We think it notable that the HIAA's position on the tax subsidy cap's revenue effects is contrary to the findings of various expert groups without vested interests that have examined this question carefully. All project significant additional federal tax revenues. Moreover, these estimates—made by the Congressional Budget Office, the Joint Committee on Taxation, and the U.S. Treasury Department—are consistent with one another and with work done at the NCHSR, which had access to the most comprehensive data base on health insurance available, the National Medical Care Expenditure Survey, sponsored jointly by NCHSR and the National Center for Health Statistics. A recent study by NCHSR projected that the tax subsidy cap proposed by President Reagan would have raised $2.3 billion in federal income taxes in 1983 had it been in effect at the beginning of the year.

The HIAA's arguments about the revenue effects of the tax cap are contradictory, illogical, and inconsistent with observed behavior:

The HIAA notes with apparent alarm that the tax cap would also "increase all employers' Social Security taxes." Of course it would, and to some degree, state income taxes would edge up as well. This is a simple fact of life with our interrelated tax system.

The HIAA's worry about a significant Social Security bite—which could occur only if the extra federal revenues generated by the cap are significant—is directly contradictory to its argument that revenue effects will be trivial. With the ceiling on the tax subsidy, some compensation that would have gone into health insurance will now be in some other form. At issue is the extent to which the substitute compensation will be taxable. The HIAA argues that it will all be in the form of tax-free fringe benefits. We think that this reflects an extreme assumption about the extent of substitution among various employee benefits.

Only if people choose to use all of the money that used to be spent on health insurance for other non-taxed fringe benefits would tax revenue stay the same. In fact, however, there is no reason to believe that people would not take most of the reduction in employer contributions as increased wages just as they take most of their overall compensation as wages.

The tax subsidy cap would reduce take-home pay slightly for some workers, but it does not change employees' preference for money wages relative to tax-free fringes. Thus, if employers want to make employees just as well off as before the tax cap, the substitute compensation will have the same mix of wages and fringes as total compensation. Since people prefer to receive most of their income in wages, most of the substitute compensation will be taxable.

III. DISTRIBUTION EFFECTS

Problems attributed to the tax cap are really problems inherent in the insurance business:

One of the most troublesome features of the HIAA attack on the tax subsidy ceiling is the attribution to this proposal of certain problematical features of the insurance business itself. Problems as old as the very concept of insurance are deceptively linked to this cap. For example, HIAA worries that under the proposed policy, "the young would subsidize the old and males would subsidize females." But it is not the tax law change that would generate such subsidies, but the very concept of a group insurance policy with a single premium. Such policies are marketed to the nation's employers by HIAA's members every day. In this sense, the HIAA rhetoric boomerangs, reflecting blame intended for the tax proposal on its members' fundamental way of conducting business.

It should be noted that we are not criticizing this aspect of the insurance business. We favor limiting risk selection as much as possible through varying the amounts of fixed subsidies going to major groups in our society. Thus, the elderly should not be grouped with the employed population, and it may be possible to vary Medicare subsidies by age and sex within the over-65 age category, reflecting the very different risk profiles of, for example, an 85-year old man and a 65-year old woman. To stipulate a different rate for every age sub-group within the employed population, however, would be carrying a good idea to the extreme. Insurers don't do it, nor should they. Yet the HIAA article raises the specter of a 20-year old secretary subsidizing a 55-year old accountant in small group insurance policies, as "each would have imputed income equal to the average of their premiums, but the secretary would be subsidizing the accountant with respect to allocated income."

As a society, we have accepted this kind of within-group employee cross subsidy. We know that most 20-year olds will be 55-year olds someday and will have their "favor" returned by tomorrow's 20-year olds. We draw the line elsewhere—we properly do not want the sick subsidizing the well (at any age) or people denied access to care because of old age or poverty (we have done better on the former than the latter). In this case, involving the natural implications of pooled risk, as elsewhere, the HIAA report uses some basic feature of the insurance market to tarnish a market reform proposal.

Regional disparities are not particularly inequitable, but if Congress wants to correct for them, it can:

Another inequity that worries HIAA involves the disparate bite of a tax subsidy cap on different regions of the country. The policy issue here involves a basic collision between equity and simplicity. Regional caps would be more equitable because some of the regional variation in premium levels is attributable to conditions beyond the control of the health care system (e.g., area wage differentials).

On the other hand, the people who would lose relatively more of their current health insurance tax subsidy would be employees with well above average earnings and/or family incomes. Since these people are better able to bear the small extra burden of having to pay taxes on employer-paid health insurance premiums above the limit (on average, six-tenths of one percent of family income), there does not appear to be a good reason on fairness grounds as to why the tax cap should be adjusted for regional variations in health care costs.

But whether the regional inequities are accepted is entirely up to Congress. And, it would surely be possible to implement the cap on a regionally differentiated basis. One major market reform bill—H.R. 850, sponsored by Congressman Richard Gephardt—details a plan to vary the cap by market area. The issue of regional disparities comes up in many tax questions, and is by no means unique to this proposal. So far, the Congress has generally chosen not to make regional adjustments in tax policy.

The tax subsidy cap will not shift the burden of premium costs from employer to employee because employees already bear it:

The HIAA report prefers to discuss the tax subsidy cap as a device that will shift the burden of premium costs from employer to employee. But careful students of the labor market have long known—from a considerable body of research evidence—that employees effectively bear the bulk of such costs anyway, regardless of whether the employer, in the first instance, pays the tab. This is true in the case of premiums as it is in the case of Social Security taxes, where the "employer share" is, in effect, largely shifted back to employees. The backward shift to employees of these costs, which the HIAA report would peg on the proposed cap on tax subsidies, has already occurred.

The real inequity is that the current tax subsidy discriminates against workers with skimpy health insurance or people who are unemployed.

If the HIAA wants to dwell on inequities, we suggest they explore the unfairness of a tax subsidy system that discriminates against workers with less generous health insurance benefits—generally, lower paid workers. These workers, along with those receiving no health insurance through their jobs, have to use after-tax dollars to buy health insurance, while employees with generous health benefits pay no tax on their employers' contribution. This tax shelter for well-paid workers siphons off scarce public dollars that could be used to assist those lacking insurance altogether, but are ineligible for Medicaid, a group that has received the short end of the public policy stick for years. And, we are talking about a subsidy recently estimated at $31 billion for 1983, a figure half again as large as the federal share of the Medicaid program.

IV. HEALTH CARE MARKET EFFECTS

The tax cap will increase the cost of health insurance and, therefore, people will buy less of it:

Making employer-paid health insurance above a set amount subject to taxation is the same thing as increasing the employee's cost of insurance, which is the difference between the after-tax price and expected benefit. As common sense and over a century of economic analysis make clear, when something costs more, people buy less of it. And, as a number of very respectable studies show, less complete health insurance coverage will lead to a lower rate of health care price inflation and spending. Moreover, it is worth stressing that less expensive health plans do not automatically translate into less generous health plans. With a subsidy cap in place, consumers will be encouraged to select plans that have equally generous benefits or covered services as other, more expensive plans, but are less costly because they exercise relatively more vigorous review of the claims and practice patterns of providers.

We do not claim that the tax subsidy cap is flawless or the only step needed to enhance to the cost effectiveness or equity of federal health policy. We do believe, however, that the problems raised by such a cap can be addressed and dealt with fairly. We also believe that such problems are not as serious as the problems embedded in current government policy or in heavy-handed regulatory alternatives to market reforms. The "all-payors" system of payment favored by the HIAA, for example, is a euphemism for systemwide price controls, and a strategy that we believe is bankrupt.

The views expressed in this letter are our own personal views, and we do not attempt to speak for our respective institutions in preparing this response. We believe that a federal tax subsidy ceiling, along with other proposed health policy changes, deserves careful scrutiny, honest debate, and a fair chance. We would be pleased to make available recent articles and books on the subject if you would find this useful.

Dr. JACK A. MEYER,
Resident Fellow in Economics,
American Enterprise Institute.

Dr. ALAIN C. ENTHOVEN,
Marriner S. Eccles Professor of Public and
Private Management, Stanford University.

Dr. WALTER J. MCCLURE,
President, Center for Policy Studies.

Dr. FRANK SLOAN,
Professor, Department of Economics,
Vanderbilt University.

Dr. GAIL R. WILENSKY,
Director of Health Information Research and
Analysis, Vice President of the Domestic Division,
Project HOPE.

Mr. DORSCH. I think that is entirely appropriate, because that answer, those learned economists said that one of the good things about the tax cap is that every possible effect will be socially good—I am paraphrasing—but you will find it in their letters.

To the extent that the Rand study says that we don't know what the effect will be on consumers' health status, obviously one of the possible effects is that it will hurt their health. I don't consider that good social policy.

Mr. MOORE. I don't think we are going to resolve this issue here. I do appreciate your testimony. Any information that you have to back up what you have, in the interest of being brief, and that is the way we normally ask you to be before the committee, to substantiate various points you made in opposition to a tax cap, I would very much appreciate so I could review that and get into it deeper.

Mr. DORSCH. We would be very happy to supply that to you directly, sir. We have sent the white paper, as a matter of fact, as part of our tax kit to every member of the committee, and I think every Member of Congress. We will get back to you again.

Mr. **Moore**. There is no constituency for a tax cap, but likewise, as I have often said before, Mr. Chairman, I don't see often a constituency for good government.

Chairman **Ford**. Thank you.

The Chair would like to thank all the witnesses who have appeared today before the joint subcommittees.

Also, we have completed the list of witnesses who have testified before the Subcommittees on Health and Public Assistance and Unemployment Compensation.

The Chair would like to say he has not been informed by the full committee when a date has been set aside for subcommittees to mark up this legislation. Therefore, the subcommittees will stand adjourned today subject to the call of the Chair.

Thank you.

[Whereupon, at 12:35 p.m., the hearing was adjourned, subject to the call of the Chair.]

[Submissions for the record follow:]

American Dental Association,
Washington, D.C., June 27, 1983.

Hon. Dan Rostenkowski,
Chairman, Committee on Ways and Means, 2111 Rayburn House Office Building, Washington, D.C.

Dear Mr. Chairman: I am writing to express the views of the American Dental Association concerning the provision of health benefits for unemployed individuals. I request that this letter be included as part of the record of the hearings the Ways and Means Committee held on this issue, and on H.R. 3021 specifically.

The ADA shares the concern of members of this Committee and the Congress over the problem of assuring continuation of health insurance benefits for persons who have lost that protection through unemployment. Many currently unemployed individuals do not have sufficient resources to maintain entitlement to their health benefits. Therefore, it is appropriate and desirable for the government to assist them on a temporary, emergency basis.

In this connection, we believe that the most efficient and effective approach would be to establish a program which supplements employer coverage. The government would pay, from general revenues of the Treasury, premiums and necessary administrative expenses directly to carriers who continue pre-existing benefit coverage on behalf of persons who would have been entitled to these benefits had their employment not been terminated.

We also must take this opportunity to express our opposition to the imposition of a tax on employee health benefits as a mechanism for financing a program of health insurance for the unemployed or for any other purpose. We do so at this time because there has not been an opportunity formally to present our views on this proposal as an independent issue to the Committee. Such a basic change in national health policy should not be enacted without a thorough consideration of its consequences and without receiving the views of representatives of those who will be most directly and seriously affected.

It is the basic position of the American Dental Association that health benefits should not be taxed. The current tax system which has assisted the development of employer based health benefits protection for the majority of American citizens represents valid social policy. This approach, which permits employer deductions for health benefits payments and does not tax employees for these contributions, has assured protection against health expenses for the majority of Americans without the need for an expensive and less efficient government financed health care system.

It is our understanding that two fundamental reasons have been advanced in support of the proposal to tax employees on certain employer health benefits contributions. These are that revenues will be raised and that increases in health care costs will be moderated because individuals will be encouraged to modify their health benefits protection in order to eliminate any tax consequences.

It is the strongly held opinion of the American Dental Association that neither goal is likely to be attained. Further, to the extent that either is reached the other cannot be. If health benefits plans are modified to avoid tax consequences, revenues will not be raised. If revenues are raised, the expected modification in benefits will not occur.

It is our position, however, that there will be a significant modification in benefits to avoid tax consequences. Unfortunately these modifications will be in dental health coverage and similar benefits which are not contributing to the rising health care cost problem, and in fact have led the way in demonstrating mechanisms for moderating these increases.

If faced with a federal policy which will impose some tax consequences, it is only logical that individuals will assure that they are comprehensively protected against the high costs of hospitalization and major medical procedures. Imposing a tax such as that proposed in H.R. 2574, the Health Cost Containment Tax Act, will not change individual demand for comprehensive coverage in these areas. Individuals will continue to be insulated from the cost consequences of the most expensive elements in our health care system.

Employees with dental or certain other types of health benefits protection who would be subject to this tax will very likely cause their employer's contributions to be switched to other non-health, untaxed fringe benefits. The result not only will be a loss of revenues, there will be a loss of a very cost effective benefit to the employee. Along with the cost effective nature of dental benefits has been a consistently improved oral health for individuals with these benefits. The ADA is absolutely opposed to a proposal which will not attain either of its goals but will result in a negative impact on the oral health of the American people. This legislation should not be adopted independently or as a mechanism for financing a program of health benefits for the unemployed.

Sincerely,

JAMES P. KERRIGAN, D.D.S.,
Chairman, Council on Legislation.

STATEMENT OF THE AMERICAN FARM BUREAU FEDERATION[1]

SUMMARY

Farm Bureau opposes the Administration's budget proposal to cap the amount of employer-provided medical care that may be excluded from an employee's income. Farm Bureau views this proposal as the imposition of a new tax to contain health care costs and reduce the deficit. We fail to see how more taxes on health consumers will cause doctors, hospitals, and other health care providers to cut costs. Farm Bureau supports reducing the deficit, but Congress and the Administration continue to look toward higher taxes rather than lower spending to reduce the deficit. We urge the Committee to reject the Administration's proposal.

The proposed cap on tax-free health insurance premiums focuses attention on a related health insurance matter—the inequity that exists in the use of income tax deductions to subsidize health insurance. For instance, many employers furnish health insurance for their employees. The full cost of the coverage is deductible to the employer as a business expense (IRC 162) and is tax free to the employee (IRC 106). The federal government is subsidizing health care for these taxpayers at the expense of two other groups of taxpayers who cannot take advantage of these tax code provisions: (1) self-employed taxpayers and, (2) employees who do not receive employer-financed health insurance coverage.

From the standpoint of self-employed farmers, there is a question of the equity of differential tax treatment for similarly situated farmers. A self-employed farmer (sole proprietor) cannot deduct the cost of health insurance premiums as a business expense. If the farming operation were incorporated, however, the farmer would be classified as an employee of the farming corporation. The corporation, as the employer, could then deduct the cost of the health insurance as a corporate business expense; and the farmer, as the employee, could receive the health insurance tax-free.

The other group of taxpayers who do not receive fair treatment under current tax provisons for health insurance coverage are employees who must buy their own health insurance. An employee or self-employed taxpayer who has to purchase his or her own insurance cannot purchase the same amount of coverage with after-tax dollars as inexpensively as an employer can furnish it to employees.

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[1] This statement was prepared for presentation to the Senate Finance Committee on June 22, 1983.

Farmer Bureau urges the Senate Finance Committee to consider these alternatives to erase the inequity that exists in the tax treatment of health insurance premiums: (1) a business deduction for the cost of a self-employed taxpayer's health insurance, or (2) a personal deduction or credit for any individual's health care insurance regardless of whether deductions are itemized.

The Administration's cap proposal should be rejected because it is actually another tax increase.

STATEMENT

Farm Bureau is the nation's largest agricultural organization representing farmers and ranchers in forty-eight states and Puerto Rico. Our policy is the result of a comprehensive policy development program at the county, state, and national levels that involves the active participation of our producer members.

Over three million member families belong to the Farm Bureau. Their livelihood is primarily in agriculture, but their interests extend to other areas such as tax, budget, and health care issues. These issues affect the economic well-being of farmers and ranchers. For this reason Farm Bureau is pleased to comment on the Administration's proposal to tax a portion of health insurance premiums paid by employers. Farm Bureau members may be employers, employees, or self-employed, but, regardless of their employment status, they are all affected by the Administration's plan to impose another tax on the public.

Farm Bureau position on the administration's proposal

The American Farm Bureau Federation opposes the Administration's budget proposal to cap the amount of employer-provided medical care that may be excluded from an employee's income. Specifically, the proposal would treat as taxable income any amount contributed by the employer for the employee's health insurance that annually exceeds $840 per individual or $2,100 per family plan.

While the Administration's rationale for this proposal is that employees would become more conscious of health care costs and that it would enhance cost containment, Farm Bureau views it as another Adminstration revenue-raising measure—a tax. In fact, Office of Management and Budget Director David Stockman has already suggested that the proposed cap levels be decreased to attribute more taxable income to employees and, therefore, more revenues to the Treasury. He has suggested that the extra money be used to finance health insurance for the unemployed. Mr. Stockman's comments indicate that the Administration is indeed considering the cap as a "revenue enhancer," not just a cost containment measure.

Our members do not consider the taxation of employer-financed health insurance premiums to be the most appropriate way to cut health care costs or to reduce the deficit. We fail to see how more taxes on health consumers will cause doctors, hospitals, and other providers to cut health care costs. The latter goal of reducing the deficit is laudable and supported by Farm Bureau, but Congress and the Administration continue to look toward higher taxes rather than lower spending to reduce the deficit.

Farm Bureau urges the Senate Finance Committee to reject the Administration's proposal to tax employees' health insurance benefits. A nearly unbearable tax burden on the middle-income class has already prompted the growth of a large underground economy that defies taxation. A new tax will neither stem health care costs nor address the real reason behind high deficits: increased federal spending the hallmark of which is uncontrollable entitlement programs. Until Members of Congress resolve to tackle the entitlement programs, our economy will continue to be plagued by high health care costs, heavy taxes, and an increasing deficit.

Inequitable tax treatment of those who self-finance their health insurance

The proposed cap on tax-free health insurance premiums focuses attention on a related health insurance matter—the inequity that exists in the use of income tax deductions to subsidize health insurance. For instance, many employers furnish health insurance coverage for their employees. The full cost of the coverage is deductible to the employer as a business expense (IRC 162) and is tax free to the employee (IRC 106). The federal government is subsidizing health care for these taxpayers at the expense of two other groups of taxpayers who cannot take advantage of these tax code provisions: (1) self-employed taxpayers and, (2) employees who do not receive employer-financed health insurance coverage.

Self-employed taxpayers

Farmers constitute a significant percentage of self-employed individuals (14 percent). The most recent figures given to us by the Internal Revenue Service indicate that in 1978 there were 1.1 million farmers out of a total of approximately 7.6 million self-employed people.

A business deduction is not available to self-employed farmers for the cost of their health insurance. The denial of a business deduction is apparently because the insurance is considered a personal expense rather than a business expense. This is short-sighted reasoning. A self-employed person has a hybrid business and employment situation, conducting business activities both as an employer and an employee. Therefore, a self-employed person should be able to deduct his or her insurance premium as a business expense under IRC Section 162 without regard to the limit for itemized deductions in Section 213. Presently, the only way a self-employed individual can deduct any amount of health insurance costs is if the premium is included as an itemized medical expense and constitutes more than five percent of adjusted gross income (IRC 213).

From the standpoint of self-employed farmers, there is a question of the equity of differential tax treatment for similarly situated farmers. For example, a self-employed farmer (sole proprietor) cannot deduct the cost of health insurance premiums as a business expense. If the farming operation were incorporated, however, the farmer would be classified as an employee of the farming corporation. The corporation, as the employer, could then deduct the costs of the health insurance as a corporate business expense; and the farmer, as the employee, could receive the health insurance tax free.

The type of a farm business organization—sole proprietorship, partnership, or corporation—determines the type of tax treatment of the farming operation. The effect of differential tax treatment could cause a farmer to consider incorporation when other business and personal factors might dictate otherwise. Farming has become an increasingly expensive business. Farmers must have access to business deductions regardless of the form of business organization they choose. The prospect of additional taxes in the next few years will take an increasing amount of money out of farmers' pockets. An income tax deduction for health insurance costs is a justifiable business expense because of the hybrid nature of self-employment.

Employee taxpayers who do not receive employer-financed health care insurance

The other group of taxpayers who do not receive fair treatment under current tax provisions for health insurance coverage are employees who must buy their own health insurance. An employee or self-employed taxpayer who has to purchase his or her own insurance cannot purchase the same amount of coverage with after-tax dollars as inexpensively as an employer can furnish it to employees. Simply put, the federal government is subsidizing health care at the expense of self-employed people and employees who do not receive employer-financed coverage.

Farm bureau position on employer-financed health care

At the 64th annual meeting of the American Farm Bureau Federation, voting delegates adopted the following policy—

> "We can support legislation to allow federal income tax credits or tax deductions for those who self-finance their health insurance."

We urge the Senate Finance Committee to consider these alternatives to erase the inequity that exists in the tax treatment of health insurance premiums: (1) a business deduction for the cost of a self-employed taxpayer's health insurance, or (2) a personal deduction or credit for any individual's health care insurance regardless of whether deductions are itemized. This alternative would help taxpayer who do not itemize, but who must pay the high cost of health insurance out of their own pockets.

Even if Congress caps a portion of employer-financed health insurance, the inequity would still exist. Those employees whose health insurance premiums are paid by their employers would continue to receive a certain level of coverage (up to $840 or $2,100 in premiums) tax-free since the premiums would fall below these cap amounts. Individuals who self-finance their health insurance would have to continue to pay their premiums with after-tax dollars. For example, a typical case of the health insurance costs of a self-employed farmer and his wife (ages 61 and 59 respectively) reveals a 1983 annual approximate cost of $2,480.00 based upon a quarterly premium of $620.00. In 1981 identical coverage cost $1,184.00 based upon a quarterly premium of $296.00 (Arkansas Blue Cross/Blue Shield Comprehensive Major Medical Group Subscriber—Family Plan, $300 deductible). Even with a $2,100 cap, employees who receive identical employer-financed coverage would receive most of the coverage tax free.

Attached to this statement are examples of quarterly Blue Cross/Blue Shield premiums for Farm Bureau members in Kansas and Michigan. The costs will "knock you off our feet." In additional to the exorbitant insurance costs, it is ironic that taxpayers no longer have benefit of the $150 deduction for health insurance premiums.

The concept of a deduction or credit for the cost of health insurance premiums could be patterned after the deductions/credits enacted in the Social Security Reform Act of 1983. Despite the recent Social Security tax increase, the new law took a step to help offset the burden of higher Social Security taxes. The new law provides that self-employed individuals will be able to take a tax credit for 1984-1989 against the self-employment tax that they must pay. After 1990, a new system of income tax deductions will be available to self-employed taxpayers. The deduction will be equal to one half of the amount of self-employment taxes paid for the taxable year. Farm Bureau believes that this type of system could be applied to reduce a self-employed person's health insurance costs.

Congress is addressing the issue of health care insurance for the unemployed. The employed, as well as the unemployed, are hurt by rising health care costs. A deduction or credit could reduce the burden, not only of higher health costs, but of the increasing tax load on the middle-income taxpayer.

Farm Bureau urges the Committee to oppose the Administration's proposed cap because it is a tax increase, and to expand, rather than restrict, the benefits surrounding the tax treatment of health insurance premiums. To do so is a matter of equity.

Thank you for the opportunity to comment on these health insurance issues.

APPENDIX

KANSAS FARM BUREAU GROUP BLUE CROSS—BLUE SHIELD

SELECTED PREMIUM EXAMPLES BASED ON AGE

[$300 deductible single plan—$600 deductible family plan]

Age category	Quarterly premium paid	
	Single	Family
Less than 30	$68.04	$157.27
30 to 34	79.65	171.64
35 to 39	89.14	182.72
40 to 44	99.75	194.51
45 to 49	111.63	207.05
50 to 54	124.92	220.39
55 to 59	139.79	234.62
60 to 64	156.44	249.75

MICHIGAN FARM BUREAU GROUP BLUE CROSS—BLUE SHIELD

Selected Premium Examples Based on Age and Area Ratings ($0 Deductible—Family Plan).

COMPREHENSIVE COVERAGE—OUTSTATE

Age category	Quarterly premium paid
Under 45	$475.53
45 to 54	706.77
55 to 64	779.37
65 and over	[1] 306.03

[1] 2 person complimentary (supplemental policy for Medicare participants).

COMPREHENSIVE COVERAGE—METROPOLITAN

Age category	Quarterly premium paid
Under 45	$637.65
45 to 54	947.61
55 to 64	1,045.02
65 and over	[1] 356.58

[1] 2 person complimentary (supplemental policy for Medicare participants).

STATEMENT OF JOHN G. BEARD, PRESIDENT OF THE AMERICAN FEDERATION OF HOME HEALTH AGENCIES

My name is John Beard. I am the President of the American Federation of Home Health Agencies. I am also Executive Director of Alacare Home Health Services, Inc., Birmingham, Alabama.

The American Federation of Home Health Agencies is a national association representing nonprofit and proprietary small business home health agencies across the United States. We represent a greater percentage of the small business home health sector than any other national organization.

I am very pleased to have the opportunity to present testimony to the Health Subcommittee of the House Ways and Means Committee on the issue of health insurance for the unemployed. AFHHA supports the concept of a Federal-State program to provide health insurance for American workers who have lost their jobs through no fault of their own. We recognize that budget resources for such a program are extremely limited. It is therefore essential that Congress draft legislation to stretch the limited funds as far as possible. To achieve this, AFHHA strongly urges you to support inclusion of a cost-saving home health provision as you consider proposals currently before your Subcommittee.

Whether the final product takes the form of HR 3021 as cleared by the House Energy and Commerce Committee, or more closely resembles the Rangel proposal currently under discussion, we urge you to seize this opportunity to steer the program in the direction of cost-effective measures and away from the expensive institutional bias that has made other Federally-funded health programs so costly. We believe that it is not enough to give lip service to controlling the spiralling cost of health programs. Concrete steps must be taken and cost-reducing alternatives must be written into legislation whenever possible. You have the opportunity here to fashion a program which will stretch resources much further than the current language of HR 3021.

Under HR 3021, a patient is eligible to receive up to nine days of inpatient hospital service and up to ten outpatient/clinic visits in a calendar year. This coverage could be quite limited for many acute illnesses requiring treatment over an extended time period. For many patients undergoing surgical procedures, home care could mean an earlier discharge that would provide the medically necessary care; whereas, under a bill without home care, a patient whose condition precluded travel to an outpatient facility would have to be hospitalized unnecessarily, using his limited inpatient days and then being left without medical coverage.

We are urging that home health services be provided as a substitute for inpatient hospital services in HR 3021. We propose that up to four skilled nursing, physical therapy, speech pathology, or occupational therapy visits, and up to six home health aide visits be substituted for each unused inpatient hospital day permitted for a calendar year in the proposed bill. To assure that the home health services would be cost-effective, reimbursement for home care services would be limited to 80 percent of the median cost of daily institutionalization. To prevent the home health benefit from becoming an "add-on" to inpatient hospital services, the benefit would be limited to patients who are either eligible for admission to or continued institutionalization at a hospital, where inpatient treatment is determined by the state's review process as being unavoidable unless the individual is furnished home health services. With your permission, I am submitting language of an amendment to HR 3021 which will provide for a home health substitution.

The population group that this health insurance legislation will cover, the unemployed, is younger that the Medicare population and the bulk of the Medicaid population. This group is more likely to have a spouse or other family members available to provide daily living support than the elderly Medicare and Medicaid population, enabling significant numbers of them to be treated at home if therapeutic services are made available.

If your committee decides to take an approach more closely resembling the Rangel proposals than HR 3021, AFHHA urges that you either specifically include a home health substitute, or that you not preclude states from including home health services in any plans they develop to implement the program.

When legislation to cover home health benefits is considered, the question inevitably arises whether home health care is in fact less costly than inpatient hospital care. Let me cite just a few examples (references in Dr. Allen D. Spiegel's recent book *Home Health Care*, Owings Mills, Md., National Health Publishing Ltd., 1983) which clearly indicate that the answer to this question is affirmative:

The Visiting Nurse Association of Milwaukee reported in 1980 that its hospital-level home care cost $28.92 per day, while average hospital costs in the area were in the $350 to $400 per day range.

A study in the Journal of the *American Medical Association* (11/21/80) reported on a Cleveland Clinic study which indicated that the average cost of providing parenteral nutrition for patients who had lost the function of the small intestine was 73 percent less that the same treatment provided on an inpatient basis. The average costs indicated in the 1976–1978 study were $202 for inpatient treatment and only $54 when the services were provided in the patient's home.

The Visiting Nurse Association of St. Louis cooperated with Blue Cross in 1979 to substitute home care for inpatient hospital care. Eighty-four patients were given home treatment in lieu of hospitalization with a net savings of $330,000.

Blue Cross and Blue Shield of Maryland reported savings of $600,000 through a home care program which facilitated early release from the hospital, or provided home care in lieu of hospitalization. The program cut an average of 9.6 days off the expected inpatient hospital confinement of 324 patients studied in 1977. Blue Cross reports savings of more than $1,000,000 last year in Maryland through the home care alternative.

A Philadelphia Blue Cross home care program reported in 1978 reduction of the average per-patient hospital stay by 12 days, or $869 per case.

Just last month you may have seen the Blue Cross/Blue Shield Association's report of a 9.5 percent reduction in the rate of hospital admissions among its subscribers for the period 1970–1981. During this time, hospitalization rates for the rest of the population were up 11 percent. In 1981, the hospitalization rate for Blue Cross subscribers was 113 per 1000 while the rate for those under 65 not covered by Blue Cross was 145 per 1000. Blue Cross attributes this startling difference to its incorporation of less costly treatment modalities, such as home care, outpatient visists, and procedures in the physician's office, in its coverage.

I believe that these examples speak for themselves. We urge your Health Subcommittee to encourage these positive developments in establishing a program of health insurance for the unemployed. You can take measures to move away from the costly institutional model contained in Medicare. Providing a limited home health benefit will establish a basis for doing just this. Failure to do so indicates that the mistakes of Medicare will be perpetuated. Here is a chance for Congress to demonstrate that there are alternatives to costly institutional care. I hope you do not miss the opportunity.

Mr. Chairman, I want to thank you and the Subcommittee for this chance to present our testimony.

Proposed Home Health Provision for Health Benefits for Unemployed

New section 2102(a)(4)(D) "for services described in Section 1905 (a)(7) (relating to home health care services), as defined by the Secretary but only to the extent they do not exceed up to four skilled nursing, physical therapy, speech pathology, or occupational therapy and six home health aide visits for each of the inpatient hospital days in (A) that are unused in any calendar year.

Old section 2102(a)(4)(1) becomes section 2102(a)(4)(E).

New section 2101(a)(5) "provide home health services furnished to an individual where—

(A) the individual is eligible for or is an inpatient of a hospital as defined in Section 1905(c) and certification has been made with respect to the individual in accordance with Section 1902 (a)(33) (relating to the appropriateness and quality of care) that—

(1) the individual is either eligible for admission or continued institutionalization at such hospital; and

(ii) the institutionalization described in Clause (i) is unavoidable unless such individual is furnished home health services;

Old section 2102(a)(5) becomes section 2102(a)(6)

Add to Section 2102(f)(1)(B)(2)(A) the following sentence after "Section 1916(b)", line 2:

A state plan may not set the amount of payment for the maximum number of home health visits provided by (or under arrangements made by) a home health agency for each day of unused inpatient hospital services in an amount that would exceed 80 percent of the daily amount that would be paid to the hospital for inpatient hospital services.

AMERICAN HEALTH CARE ASSOCIATION,
Washington, D.C., June 27, 1983.

Mr. JOHN SALMON,
Chief Counsel, House Ways and Means Committee, 1102 Longworth House Office Building, Washington, D.C.

DEAR JOHN: In regard to the Ways and Means Committee mock-up of Health Care for Unemployed (H.R. 3021), we urge that such legislation have as small a financial burden for states as possible. Expressing particular concerns about other proposals which would have harmful implications for Medicaid and other hard-pressed states' services.

Sincerely,

GARY F. CAPISTRANT,
Director, Office of Congressional Relations and Public Policy, Government Affairs Department.

STATEMENT ON HEALTH INSURANCE FOR THE UNEMPLOYED [1]

We are sympathetic with the health care need of unemployed workers who have lost their employee-based health insurance. If the federal government establishes a new program of assistance to these people it should be fully funded by the federal government. The unemployment problem is a consequence of the nation's economy and the federal government should be responsible for any new public program to reduce its effects.

We are concerned that states, already financially pressed because of the recession and subjected to federal budget cuts, not be expected to further cut its remaining services to contribute to this new commitment. In particular, we are concerned with legislative proposals which offer states a lower state matching rate for meeting the health needs of the unemployed than for the welfare recipients and medically needy. The "old poor," Medicaid patients, should not be pitted against the "new poor," unemployed workers. For many states, Medicaid is the largest single budget item and has been the target of major budget cutting. States should not be placed under political and financial pressure to shrink its effort to Medicaid recipients for this new program.

We understand the interest of elected representatives in enacting health insurance for the unemployed and urge that it not be achieved at the expense of even more critical social priorities and existing programs.

AMERICAN PSYCHIATRIC ASSOCIATION,
Washington, D.C., June 21, 1983.

Hon. ANDY JACOBS,
Chairman, Subcommittee on Health, House Committee on Ways and Means, 1102 Longworth House Office Building, Washington, D.C.

DEAR MR. CHAIRMAN: The American Psychiatric Association, a medical specialty society representing over 28,000 psychiatrists nationwide is pleased to provide our comments on H.R. 3021, the "Health Care for the Unemployed Act" and requests these comments be made part of the Committee's June 17, 1983 hearing record on this most important subject.

The APA commends the Committee for its consideration of this legislation to address the severe problems confronted by the millions of Americans who by losing their jobs, have lost their health insurance protection. You may be assured that psychiatry, as all of medicine, is proud of the initiatives we have participated in to provide free, vitally needed medical care to the unemployed. Unfortunately, it has not been enough, and the pervasive nature and magnitude of the of the unemployment problem has led us to conclude, as did the American Medical Association, that a temporary, nationwide program to provide health insurance for the unemployed is necessary. Thus, we were gratified when the House Committee on Energy and Commerce adopted and referred to the Ways and Means Committee H.R. 3021.

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[1] Adopted by the Legislative Committee, June 5, 1983.

BENEFITS

We note that the bill before the Committee provides nine days of inpatient hospital services in a 12 month period; 10 visits for outpatient hospital and physician services in any 12 month period; family planning and nurse midwife services; and Secretarilly limited laboratory and x-ray services. We are concerned, however, about the provision which permits state plans to impose premiums, enrollment fees, deductions, cost-sharing and other similar requirements.

While we do not disagree conceptually with the imposition of such features, we are concerned that they be adopted across all diagnostic categories—not singling out the mentally ill or substance abusers for disparate coverage. Whatever the eligibility, administration, financing or duration of the program, the benefit package should not provide disparate coverage for the treatment of mental illness from that provided for physical illness. Whether it is inpatient hospital care, emergency outpatient hospital services, physicians' services (in or outpatient), the bill adopted by the Committee should, in the words of the American Medical Association, "provide comparable benefits for the treatment of physical and mental illness." (Report of the AMA Council on Legislation, March 25-27, 1983, as approved by the Board of Trustees). Whatever the coverage, no distinction between physical and mental illness should be made in the amount, duration or scope of that coverage. We hope the Committee will include report language in the report accompanying the measure which responds to this concern.

FINANCING

The APA is deeply concerned about the use of a so-called "health insurance tax cap," requiring any sums above a specified "cap" contributed by an employer to an employee's health insurance to be considered taxable income to the employee, as a legitimate means of funding H.R. 3021, or any other measure providing health insurance to the unemployed.

Last year, the Congress adopted as part of TEFRA an increase to five percent in the minimum of adjusted gross income for out-of-pocket health expenditures above which level a tax deduction for health care may be taken on income taxes. Taken together, the TEFRA change and the proposed "health insurance tax cap" represent yet another tragedy for the mentally ill, mentally retarded and handicapped, all of whom are among the most at risk for high health care costs. If the health insurance tax cap, as the proposal intends, results in the development of less costly health insurance programs—the so-called "competition" incentive—the cost to the mentally ill, retarded or handicapped will be further increased. We know from recent painful experience with the Federal Employee Health Benefit Program that when benefits must be cut—and in this case, they would be, to reduce premium cost—the first services to be reduced are those for the very populations we represent or treat. The potential impetus for such health insurance plan changes generated by employees whose tax status would change with higher premium plans is tremendous, and history has well instructed us that the voiced or unvoiced concerns of the mentally ill, mentally retarded or disabled are not heeded at such times.

As our patients' and their families' health insurance premiums might be reduced, it would be achieved by focusing in on a cutback in medical benefits for the treatment of mental illness—as documented by recent FEHBP and HMO administrative activity. This would cause greater out-of-pocket expenses which will not now be offset for income tax purposes until such medically necessary expenditures reach an unprecedented 5 percent of adjusted gross income.

We urge the Committee to consider the veritable Pandora's box it may open before it establishes any change in the existing tax status for employer paid health insurance premiums. Other means of funding a program to provide health insurance for the unemployed which does not impose a severe economic hardship for those now fortunate to be employed should be found.

Sincerely,

JAY B. CUTLER,
Special Counsel and Director, Division of Government Relations.

STATEMENT OF HON. LYNN MARTIN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to comment on the issue of health care for the unemployed. While all will agree that a problem exists, there is less consensus on the scope of the problem and on how best to meet the need.

I represent an area whose economic livelihood is largely dependent on the automobile, housing, machine tool, and steel industries. With that makeup, there is no wonder that unemployment has hit my constituents especially hard.

But in this adversity, the people of Northern Illinois have joined together to help the unemployed. Their efforts include identifying and meeting the needs on a community level, closest to the people. It is for that reason that I feel compelled to comment on the federal effort to provide health care coverage for the unemployed.

It never ceases to amaze me how often we, as federal legislators, approve legislation that runs directly counter to private sector initiatives. It seems as though there is an underlying belief that if federal dollars are involved, it is best for all.

Nonetheless, I do not intend to discuss the longstanding debate on public versus private problem solving. What now concerns me is the growing momentum to implement costly federal legislation that will discourage and/or preclude community efforts. It occurs to me that our effort should be directed toward strengthening already established private sector initiatives rather than undermining them, which is exactly what will happen under the provisions of most of the proposals.

I bring to your attention one such example. The Rockford, Illinois area several times last summer had the dubious honor of leading the nation in unemployment. Although its rate has subsided somewhat, the fact remains that over 16,000 manufacturing jobs have been lost since 1979. Moreover, the average unemployment rate for this metropolitan area is not expected to stabilize below 16 percent for quite some time.

This translates directly into thousand of persons who have either lost or no longer can afford health care insurance. Like other communities nationwide, Rockford is gearing up to meet this call for help.

Rockford's mayor appointed recently a Health Services Task Force, comprised of representatives from the medical and social services fields. This 20-plus member panel was given the mandate to address the health care needs of the jobless.

One of the major proposals on which they are working is the establishment of a health care clinic for the unemployed, staffed by medical professionals volunteering their services. These people, whose community has fallen victim to difficult economic times, believe they are the best ones to meet the health care needs of their jobless neighbors. Still, a major stumbling block in their effort is money for supplies and equipment.

It seems more appropriate to strengthen community efforts like this through a grant program that would enable these self-help efforts to purchase needed supplies and equipment than to implement legislation that, in effect, will discourage their continuance. Federal dollars may be needed, but the enactment of a multi-billion dollar program that will further aggravate our deficit dilemma is unwise and simply bad public policy.

As the Committee considers this health care problem. it is my hope that it will keep in mind community efforts like Rockford's. In these times of limited federal dollars, we must legislate responsibly. If community efforts presently underway are trying to meet the health care needs of the unemployed, they should be encouraged and strengthened, not replaced by an expensive, bureaucratic program.

National Association of Casualty & Surety Agents,
Washington, D.C., June 17, 1983.

Hon. Andrew Jacobs, Jr.,
Chairman, Subcommittee on Health, House Ways and Means Committee, Washington, D.C.

Dear Chairman Jacobs: The National Association of Casualty and Surety Agents (NACSA), an association representing the leading domestic, commercial insurance agencies and brokerage firms, recognizes the need for a limited program to assure continued health care for the nation's unemployed during this period of recession. However, NACSA opposes funding this program with revenue collected through the Administration's proposal to tax employee health care benefits. NACSA believes such a tax on employee health benefits would be unfair.

This tax would discriminate against older and handicapped workers, against employees in high-risk occupations, and against those living in areas with a high cost of living. These groups pay higher premiums than the average for the same health care insurance. It would be unfair if these workers were to pay more in taxes than others for the same health protection.

This tax would constitute a form of double taxation. Since the government does not reimburse hospitals for all costs associated with treating Medicare/Medicaid patients, the private sector is forced to absorb the difference. In 1982 alone, this 'cost shift' amounted to $5.8 billion. This, in effect, is a hidden tax. It would be unfair for the government to shift these costs to private payors of health care and tax the resulting higher premiums.

NACSA urges you to reject the Administration's proposal to fund health benefits for the unemployed by means of a tax on employee health care benefits. This tax would be unfair under any circumstances; even providing health care benefits to the unemployed does not justify its use.

We respectfully request this letter be included in the record of the joint hearing held by your subcommittees on Health and Public Assistance and Unemployment Compensation held on June 17, 1983.

Sincerely,

Joan Albert Dreux,
Government Affairs Director.

The National Association of
Private Psychiatric Hospitals,
Washington, D.C., June 21, 1983.

Hon. Dan Rostenkowski,
Chairman, House Ways and Means Committee, 1102 Longworth House Office Building, Washington, D.C.

Dear Congressman Rostenkowski: The National Association of Private Psychiatric Hospitals, representing the nation's nongovernmental, specialty, psychiatric hospitals, urges the defeat of any proposal under discussion before your committee, which would place a ceiling on the tax exclusion of an employer's contribution to its employee's health insurance premium.

This Association opposes such a ceiling and feels that it would fail to recognize the discrepancies in medical costs on the following bases: geography, age, population intensity, provider distribution, and nature of illnesses, to list but a few.

Most importantly, this Association, along with the hospitals we represent, the patients they serve, and the providers who serve them, feels such a ceiling would signal the reduction of coverage for psychiatric benefits since health insurance policies would no doubt be restructured to fit a lower premium dollar.

This Association is on record as agreeing that increased competition is needed in the health care system, to help curtail rising costs. Any such system, though, must be implemented through regulation which assures that consumers and employers are protected from plans which exclude necessary health services. The proposed tax ceiling on an employer's contribution to the employee's health insurance premium would no doubt concentrate the employer contributions on first dollar hospital/surgical coverage and continue to erode the basic psychiatric benefit now in place, as well as impede the development of competitive health plans, alternative health services, and preventive services.

While the equity considerations of such a proposal cannot be underestimated, the administration of a dollar ceiling on each employee's exclusion also would be complicated at best and impossible to administer at worst were it to extend to those employers now self-insured. Additionally, the proposed ceiling would not have significant effect on the rate of increase of medical care costs since the employees would no doubt assume the cost differential by purchasing supplemental insurance. Finally, the proposal would likely have a minimal effect on tax revenues since it would not affect all employees of the work force. We also question how great a revenue increase would accrue given the likelihood that employers, during their negotiations with employees, would shift the benefit now given as a health insurance premium to other nontaxable fringe benefits.

Lastly, it is estimated that the government cuts in the Medicare program, which are estimated at $5 billion for the current year, would be shifted to the private sector resulting in higher premiums. The proposal under discussion can only serve to further the arbitrary exclusion of certain health benefits from insurance coverage in the private sector in order to fund this massive cost shift.

This Association hopes that you and the members of your committee will not support this proposal which unfairly increases the taxes of a limited number of working persons. We look forward to working with you as the deliberations continue.

Sincerely,

JOY MIDMAN,
Associate Executive Director.

STATEMENT OF THE NATIONAL EDUCATION ASSOCIATION

For many years the National Education Association has vigorously supported legislation to bring about necessary reforms in health care—to provide quality services wherever they are needed, with special emphasis on preventive medicine and strict controls on costs.

We have done so because the American people are not getting their money's worth in health care. We spend more than $300 billion a year on health services, but those services are unevenly and inequitably distributed. The poor and the unemployed are notoriously underserved. The remedy, of course, is a comprehensive and universal national health insurance program. But we are far short of attaining that goal.

In fact, we are arguing about trickles in a flood of inequities. One such trickle is the Administration's preposterous proposal to put a tax cap on health benefits for those who are employed and whose employer puts up a part of the premium or enrollment costs in a health plan.

The immediate purpose of this proposal is to raise some cash. It's not a very good idea even for that purpose. Actuaries know that marketplace behaviour is very unpredictable, and that it does not necessarily follow that placing an arbitrary limit on the tax exemption for health benefits will raise any money at all. People—healthy, young people—may simply opt for lower-cost insurance, which means lower benefits and substantial risk-taking on their part. This group would pay no taxes at all on health benefits.

Those who are older and/or in failing or fragile health would probably choose to stay in a high-coverage plan. In addition to being sick, they would pay taxes on top of whatever coinsurance and deductibles might be part of their plan (even high-option plans have deductibles).

So the tax-raising measure would tax those with high health risks and encourage younger, healthier workers to take chances on their coverage. NEA views this proposal as an unwise and counterproductive tax device, and as a dangerous incentive to reduce health care benefits.

Some specific consequences of this proposal are immediately evident.

1. Taxing health insurance benefits could encourage employers to drop health benefits for workers who have been laid off. This would be a catastrophic blow to these workers.

2. The tax cap would be a disincentive to employers who might otherwise hire older workers or workers with health problems; the health benefit coverage costs would probably exceed the tax exempt amount for these workers.

3. Because of added costs of covering employees who are older or who have health problems, employers would be encouraged to force such workers to retire early—or simply to dismiss them.

NEA members—1.7 million employees in public schools and in the nation's colleges and universities—are among those who could be most seriously affected by the Administration's tax cap plan. They are unalterably opposed to such a plan, and want to convey to the Ways and Means Committee their demand for greater, not lesser, tax equity and greater, not lesser, health care protection. The Association is convinced that there are better ways to contain health care costs than to place large segments of the working population at greater risk. One such means would be enactment of a health cost containment plan as advocated by the Committee for National Health Insurance. This plan would set the stage for meaningful and necessary reform in the delivery of health care and its financing. And unlike the Administration's various proposals to reduce federal assistance for social programs, it would start to make life better for the working American.

STATEMENT OF UNITED AUTO WORKERS INTERNATIONAL UNION

Mr. Chairmen, my name is Dick Warden. I am Legislative Director of the United Auto Workers International Union. I speak on behalf of more than one million active and retired members of the UAW. We want to voice strong support for H.R. 3021, the Health Care for Unemployed Act, reported favorably by the Energy and Commerce Committee with strong bipartisan support. We are pleased to note that the Chairmen of these two Subcommittees are cosponsors of H.R. 3021.

We commend your Subcommittees for addressing the tragic loss of health protection by families of the unemployed, which is one of the most cruel by-products of the current economic depression.

The extent and the seriousness of the loss of health insurance is well known. The Congressional Budget Office has estimated that 14 million unemployed workers and their dependents were without health insurance in February and that 21 million will lose protection some time during this year. Our estimates are even higher. According to a Department of Labor study, close to 60 percent of workers lose their health protection immediately or within a month of layoff. Only 20 percent have protection continued beyond 3 months.

The cost of purchasing non-group insurance policies has soared beyond the severely reduced means of families of the unemployed. The family premium for a UAW-General Motors policy in Michigan is currently $302 per month. Converting this to individual payment with substantially fewer benefits costs about $200 per month. That is why the rate of conversion to this coverage in Michigan is only about 5 percent.

The limited family budget of the unemployed worker is seriously strained by competing essential priorities. Mortgage or rent payments, threatened utility cut-offs, merely putting food on the table are the harsh everyday realities. There is no money for health insurance. And receipt of necessary medical treatment is often ignored, or delayed with sometimes severe consequences, in the struggle for day-to-day survival.

At the same time, researchers have documented the strong relationship between job loss and higher rates of illness and death. High rates of unemployment are associated with dramatic increases in suicide, homicide, fatal heart disease, cirrhosis of the liver and other stress-related illness. Excessive drinking, smoking, anxiety, insomnia and high blood pressure are symptoms of joblessness that add to the despair, tension and depression experienced by families with a laid-off breadwinner.

According to the chairman of the President's Council of Economic Advisors, this problem will not readily diminish with economic recovery. He expects high rates of unemployment to persist for up to five more years.

Under major UAW contracts, health insurance coverage for laid-off workers continues for up to a year depending on length of seniority. But these contractual benefits are not typical for most workers, nor for many members of our Union who lose coverage at the point of layoff. I must tell you with deep sorrow that, even with the extended health insurance coverage, at least 300,000 laid-off UAW members have run out of health insurance protection. Most of them are denied Medicaid coverage because they are not considered poor enough.

Many public and non-profit community hospitals currently find their existence threatened by the increase in free care they must provide to jobless patients. Many may not be able to continue to meet this need.

Recognition of the serious plight of the jobless has spawned a number of voluntary efforts on the part of community leaders, labor unions, hospitals and physician groups around the country to provide some health care services for families of those on layoff. These are helpful and commendable activities which should continue. They hardly begin to solve the problem, however. The information we receive from UAW local unions and regional offices around the country indicates that: (1) such efforts are very spotty; (2) they have served relatively few in relation to the known need, (3) they seldom provide the financial support to pay for expensive services, such as hospitalization, when needed; and (4) laid-off workers who have always provided for their families' needs are usually too proud to ask for charity care, except in the most urgent circumstances.

The economic and human consequences of this extensive loss of health care protection are difficult to project with certainty. The cost to the nation in damaged and lost lives may be as costly as the loss of productive employment itself. For the past three years, calls by leaders of our Union and others to address this situation all too often have seemed to fall on deaf ears, while the disaster mounted. Against this background of frustration, we now welcome the genuine interest on both sides of the aisle, in both houses of Congress in stepping up to this responsibility.

We strongly support H.R. 3021 to authorize an effective program of health care for the unemployed. This, we believe, should be a matter of utmost urgency for the Congress, and we urge its speedy enactment. H.R. 3021 embodies several important principles which we believe are essential in attacking the problem we have described.

1. First, H.R. 3021 does not require a means test for determination of eligibility for benefits, as some have proposed, and which members of our Union and other laid-off workers would find abhorrent.

2. The bill would set reasonable national standards for eligibility, covered services and cost sharing for this vulnerable population group. Unlike some other proposals, H.R. 3021 would assure that a minimum level of health care protection would be provided for an identifiable segment of our population—families which have suffered, and continue to suffer because of unacceptably high rates of unemployment.

3. This legislation establishes the principle of greater federal support for states and areas which have been hardest hit by unemployment and, therefore, are least likely to have financial resources for this cause. Very importantly, it would require no state match of funds for those states racked by the severest unemployment.

4. The benefit package is not as comprehensive as we would prefer. We believe it should, at a minimum, match Medicaid benefits. But the program does provide a package of services which are essential and which can be supplemented by other sources.

5. Under H.R. 3021, cost sharing in the form of premium payments or copayments and deductibles would be minimal, recognizing the reduced circumstances of the unemployed. Copayments and deductibles would be no more than those required by state medicaid programs.

6. Under H.R. 3021 recognizes the longstanding nature of the current economic downturn, and reaches back as far as feasible to include the long-term unemployed, the group hardest hit and most in need.

7. Because of the extremely high number of unemployed in the current depression, this bill would provide some special assistance (although, admittedly a very limited amount), for public hospitals in high unemployment areas. All too often those public hospitals are the providers of last resort for growing numbers of low-income individuals who will continue to be without any private or public health coverage, even if a program along the lines we are discussing is enacted.

It is estimated that the cost of the program proposed in H.R. 3021 would be approximately $2.6 billion—less than the amount allowed in the House budget resolution for health care for the unemployed. We believe that even this amount will not adequately address the problem; it is less than one-half of the $6 billion the Congressional Budget Office estimates would be required to extend even limited Medicare benefits to those who have lost their health insurance.

However, H.R. 3021 is a well-designed program and represents a major first step toward ameliorating a problem which indeed amounts to a national disgrace.

We sadly recognize there will continue to be large numbers of Americans with limited incomes in need of health care who will be ineligible for assistance from existing public and private programs, and even from the program we are supporting today. Logic and experience dictates that over the long run only comprehensive national health insurance, with effective, built-in cost controls, will be recognized as the appropriate solution to these problems. As an intermediate range answer to part of the problem, H.R. 3021 is a crucial response to an urgent, compelling situation. We urge its speedy enactment.

In conclusion, we wish once again to commend you and your Subcommittees for holding this hearing. We urge you to move expeditiously on this critically-important legislation.

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